

# Medical History

Date: \_\_\_\_\_

Patient: \_\_\_\_\_ Pharmacy: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Are you allergic to any medications?  YES  NO If yes, list:

1. \_\_\_\_\_ 2. \_\_\_\_\_

List all Medications you are currently taking:

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO	Other Systemic:	YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Stomach	<input type="checkbox"/>	<input type="checkbox"/>
			Bowel	<input type="checkbox"/>	<input type="checkbox"/>
			Hepatitis or Yellow Skin	<input type="checkbox"/>	<input type="checkbox"/>
			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
			Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
			Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>

Vascular:

	YES	NO
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>

Do you drink alcohol?  YES  NO

Do you use IV drugs?  YES  NO

Have you had or have you been exposed to HIV (AIDS)?

Have you ever had dental anesthesia (Novacaine)?

If YES \_\_\_\_\_ drinks per day

If YES, what? \_\_\_\_\_ How much? \_\_\_\_\_

YES  NO

YES  NO Any bad reactions?  YES  NO

Skin:

When you are exposed to sun do you:

Tan Only  Tan and burn  Burn

Have you ever had skin cancer?

YES  NO

Has anyone in your family had skin cancer?

YES  NO

Do you have a history of any specific skin diseases?

YES  NO

If yes, please list: \_\_\_\_\_

List any other disease or condition we should know about: \_\_\_\_\_

List surgical procedures you have had in the last 6 months: \_\_\_\_\_

Please answer the following questions:

A. Do you smoke?  YES  NO If YES, how much: \_\_\_\_\_

B. Do you bleed easily?  YES  NO

C. (Women) Are you pregnant?  YES  NO Due Date: \_\_\_\_\_

D. Do you have artificial joint(s)?  YES  NO

E. What is your occupation? \_\_\_\_\_

F. What are your hobbies? \_\_\_\_\_

Completed by:  Patient  
 Medical Assistant \_\_\_\_\_  
Initials

Signed by Physician \_\_\_\_\_ Date

Reviewed by \_\_\_\_\_ Date