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Medical History Form

Patient Name: ______________________________ Age:____________ Sex: ____________

Family Physician: ____

Referred to this office by: ____

Allergies: 1.______________________ 2.______________________ 3. ______________________ 4. ______________________

Current Medications: 1.______________________ 2.______________________ 3.______________________ 4. ______________________ 5.______________________ 6.______________________

Do you have or have you ever had:		
Eczema	☐No	☐Yes
Psoriasis	☐No	☐Yes
Skin Cancer	☐No	☐Yes
Acne	☐No	☐Yes
Sarcoidosis	☐No	☐Yes
Lupus	☐No	☐Yes
HIV+	☐No	☐Yes
Abnormal Scarring/Keloid	☐No	☐Yes
Cold sores/Fever blisters	☐No	☐Yes
Diabetes	☐No	☐Yes
Hypertension	☐No	☐Yes
Heart Disease	☐No	☐Yes
Pacemaker	☐No	☐Yes
Heart Valve Problems	☐No	☐Yes
Hay Fever	☐No	☐Yes
Asthma	☐No	☐Yes
Kidney Disease	☐No	☐Yes
Liver Disease	☐No	☐Yes
Psychiatric Illness	☐No	☐Yes
Depression or Anxiety	☐No	☐Yes
Cancer	☐No	☐Yes
Seizures	☐No	☐Yes
Bleeding or Clotting Disorder	☐No	☐Yes
Artificial Joint	☐No	☐Yes
Other	☐No	☐Yes

List any surgeries (operations):

1. ____/____/____
2. ____/____/____
3. ____/____/____

Have you had any surgery in the past 3 months?

☐No ☐Yes

Have you ever had surgery for skin cancer?

☐No ☐Yes

Site: ______________________________

Kind: ______________________________

Do you require antibiotics **before** you go to the dentist?

☐No ☐Yes

Do you take any blood thinners like aspirin, Coumadin, other: ______________________________

☐No ☐Yes

Any Medical Conditions not listed above?

____

MEDICAL HISTORY FORM (CONT.)

Have you had any of the following conditions in the past 3 months?		
Change in weight	☐No	☐Yes
Change in appetite	☐No	☐Yes
Breathing problems	☐No	☐Yes
Respiratory Infections	☐No	☐Yes
Persistent Cough	☐No	☐Yes
Angina/Chest Pain	☐No	☐Yes
High Blood Pressure	☐No	☐Yes
Bloody or Dark Stools	☐No	☐Yes
Diarrhea	☐No	☐Yes
Nausea or Vomiting	☐No	☐Yes
Painful Urination	☐No	☐Yes
Blood in Urine	☐No	☐Yes
Abdominal Pain	☐No	☐Yes
Jaundice	☐No	☐Yes
Arthritis	☐No	☐Yes
Fever	☐No	☐Yes
Headache	☐No	☐Yes
Visual Changes	☐No	☐Yes
Fatigue	☐No	☐Yes
Muscle Weakness	☐No	☐Yes
Anemia	☐No	☐Yes
Thyroid Problems	☐No	☐Yes
Dizziness or Passed Out	☐No	☐Yes
Other problems of skin (Please explain)	☐No	☐Yes

Do you have a history of:		
Blistering sunburns	☐No	☐Yes
Tanning bed use	☐No	☐Yes
Working as a lifeguard	☐No	☐Yes
Sun exposure from sports	☐No	☐Yes
Abnormal moles removed in past	☐No	☐Yes
Does your job require sun exposure?	☐No	☐Yes
Do you wear sunblock every day?	☐No	☐Yes
What kind?	SPF: ________	

Do you have a family history of?		
Eczema	☐No	☐Yes
Hay Fever	☐No	☐Yes
Psoriasis	☐No	☐Yes
Acne	☐No	☐Yes
Skin Cancer Type:	☐No	☐Yes
Other? List:	☐No	☐Yes

Do you smoke? ☐No ☐Yes

How Much? ________________________

How Long? ________________________

Do you drink alcohol? ☐No ☐Yes

How Much?

Occupation:

____

For Women Only:		
Age at first period?	______	
Are your periods regular?	☐No	☐Yes
Date of last period:	____/____/____	
Have you ever been Pregnant?	☐No	☐Yes
How many times have you been pregnant?	_______	
Have you ever had a Miscarriage?	☐No	☐Yes
Are you currently Pregnant?	☐No	☐Yes
Are you currently Breastfeeding?	☐No	☐Yes
Are you planning to become pregnant in the near future?	☐No	☐Yes
Are you on an oral birth control pill?	☐No	☐Yes
Age at menopause:	______	

Patient / Guardian Signature:____ Date: ____/____/____

Physician Signature:____ Date: ____/____/____