PATIENT MEDICAL HISTORY

Patient: ____ Age: ____ Date: _______________

Reason for today's visit: ____

Present for how long? _____________________________ Does it itch? Y N hurt? Y N burn? Y N bleed? Y N

Current treatment: ____

Are you allergic to any medications? Y N If yes, list below:

____

Current medications you are taking: ____

Do you have now, or have you ever had diseases or conditions of: (please circle Y or N)

Pacemaker	Y	N	Diabetes	Y	N
Yeast infection			Arthritis/joint deformity	Y	N
when taking antibiotics	Y	N	any artificial joint	Y	N
Fainting	Y	N	Mitral valve prolapse	Y	N

List any other diseases or conditions: ____

List surgical procedures you have had: ____

Skin conditions:

Have you ever had skin cancer? Y N
Has anyone in your family had skin cancer? Y N
Do you use sunscreen regularly? Y N
Do you have a history of any specific skin diseases? Y N If yes: ______________________________
Do you develop keloids (scars) after surgery? Y N
Do you bleed easily? Y N
Do you develop skin rashes in reaction to: medications food environment ________________________

Social history:

Do you drink alcohol? Y N If yes ________drinks per day
Do you use IV drugs? Y N If yes, what? _________________ How often? ________________
Do you smoke? Y N If yes, how much? ____

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

Please answer the following questions:

(Women) Are you pregnant? Y N Due date: _______________

What is your occupation? __________________________________

Hobbies? ____

Completed by: ☐ patient

☐ medical assistant ________ initals

____
signed by patient date

____
reviewed by date