MEDICAL HISTORY FORM

Date: _____ MR #: _____

PATIENT INFORMATION

Last Name: _____ First: _____ Middle: ____ Birth date: _____ Age: ____

Do you have a referring Provider: Yes No If so, physicians name: _____

REASON FOR TODAY'S VISIT

	Concern:	Location:	Duration:	Prior Treatments:
1)				
2)				
3)				

*If you have more than three concerns to address with your provider, we ask that you schedule another appointment as a courtesy to our other patients.

PAST MEDICAL HISTORY

Anticoagulant treatment	Yes	No	HSV/cold sore	Yes	No
Bleeding disorders	Yes	No	Eczema	Yes	No
Pacemaker/defibrillator	Yes	No	Asthma	Yes	No
Immunosuppressed	Yes	No	Hay fever	Yes	No
Organ transplant	Yes	No	Heart disease	Yes	No
Hepatitis	Yes	No	Artificial joint	Yes	No
HIV positive	Yes	No	Kidney disease	Yes	No
Tuberculosis	Yes	No	Thyroid disease	Yes	No
Diabetes	Yes	No	Lupus	Yes	No
Pre-op/pre-dental antibiotics	Yes	No	Arthritis	Yes	No
MRSA	Yes	No	Psoriasis	Yes	No
Abnormal scars	Yes	No	Artificial heart valve	Yes	No
Poor wound healing	Yes	No	Difficult to numb	Yes	No
			Other _____	Yes	No

CURRENT MEDICATIONS

	Medication:	Frequency:	Dose:	Route:
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				

* If you need more space for additional medications, please use the back of this page.

Preferred Pharmacy and Location: _____

ALLERGIES/VACCINES

Do you have any medical allergies? Yes No **Pneumococcal vaccine (Pneumonia vaccine)** **Yes** **No**

List Allergies: _____

SKIN CANCER HISTORY

Do you have a history of melanoma? Yes No If yes, location: _____ Depth: _____

Do you have a history of other skin cancer(s)? Yes No If yes, location: _____

Do you have a family history of Melanoma? Yes No If yes, relationship: _____

SOCIAL HISTORY

Do you use tobacco? Yes No

Do you consume alcohol? Yes No

If yes, how often? _____

Occupation: _____

FOR WOMEN ONLY

Are you pregnant?	Yes	No
Are you breastfeeding?	Yes	No
Are you on birth control?	Yes	No