

HISTORY

Date: _____
Update: _____
Update: _____

NAME _____ Date of birth: _____

TELEPHONE NUMBER to reach you with information or results _____

May we leave medical information or test results on your answering machine? _____ YES _____ NO

Primary Care Physician: _____

MEDICAL HISTORY:

1. Major Illnesses/Hospitalizations/Chronic conditions _____

2. Surgeries _____

3. Do you have any of the following (check all that apply):

- | | | |
|-------------------------------------------------------------|--------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Hypertension (High Blood Pressure) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease (Murmur) |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Artificial Heart Valves/Stents |

Explain checked items: _____

MEDICATIONS: (Include creams and supplements)	Name	Dose	How often
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____

ALLERGIES TO MEDICATIONS: _____

Allergy to latex: Yes No Allergies to foods or environment? _____

Do you need to take antibiotics prior to dental or surgical procedures? Yes No

Do you smoke? Yes No How much? _____ Do you drink alcohol? Yes No How much? _____

SKIN HISTORY: (List onset, duration, any treatments)

1. General problems: _____

2. Skin cancer history: _____

3. Severe sun exposure: _____

4. Chronic X-ray treatment: _____

5. When exposed to sunlight, do you: _____ Burn _____ Burn-tan _____ Tan only

FAMILY MEDICAL HISTORY: (List any medical problems/conditions of family members)

1. Mother _____

2. Father _____

3. Children/Siblings _____

Patient Signature: _____ Date _____