MEDICAL HISTORY

Patient: ______________________________________ **Date of Birth:** ____/____/____ **Today's Date:** ____/____/____

Reason for today's visit: ____

How long have you had this problem? _______________________ **Occupation:**______________________________

Who referred you? ___ I have been a previous patient ___ Family or Friend _______________________________
(Name of family member or friend)

___ Website ___ Insurance plan ___ Yellow pages ___ (Google, Yahoo, etc.)

___Physician **Physician's name and address**: ____

Do you want a report sent to this physician? Y N

List all medication you are currently taking (including prescriptions, over-the-counter meds, vitamins and herbals)

1. ____________________________ 3. ____________________________ 5. _________________________

2. ____________________________ 4. ____________________________ 6. _________________________

Please list any medications you are allergic to:____

Are you Pregnant?	Y	N	Plan on becoming pregnant?	Y	N
Breastfeeding?	Y	N	Are you on birth control pills?	Y	N

Do you have now, or have you ever had any of the following: (Please circle YES or NO)

Respiratory:			**Other:**		
Asthma	Y	N	HIV	Y	N
Chronic Bronchitis	Y	N	Diabetes	Y	N
Emphysema	Y	N	Blood Clots in Legs	Y	N
Hayfever	Y	N	Hives	Y	N
Valley Fever	Y	N	History of Mental Illness	Y	N
Cardiovascular:			Kidney Disease	Y	N
Bleeding Problems	Y	N	Tuberculosis	Y	N
Heart Disease	Y	N	Arthritis	Y	N
High Blood Pressure	Y	N	**List any other diseases**: ____________________		
Gastrointestinal:					
Ulcers	Y	N	____		
Hepatitis B or C	Y	N			

Skin:

Have you ever had skin cancer? Y N Type ___________________ When? ______________________

Has anyone in your family had melanoma skin cancer? Y N Who? ______________________________

Do you have a history of eczema (atopic dermatitis)? Y N

Has anyone in your family had ____ asthma ____ hay fever ____ eczema? Who? _____________________________

Do you develop skin rashes in reaction to ___ Bandages ___ Topical Neosporin (antibiotic) ___ Latex

Do you smoke? Y N Do you ever use a tanning bed/booth? Y N

Do you have a history of alcohol or substance abuse? Y N

Do you have any medical prosthetics, artificial valves, joints or pacemaker? Y N

Pharmacy Name _________________________________**Pharmacy Phone Number** _________________________________

Pharmacy Address or Cross Streets____

Provider Signature ____ **Date** ____/____/____