

MEDICAL HISTORY

TODAY'S DATE _____

Patient Name: _____ Date of Birth: _____

Current Medications: _____

What medications are you allergic to?

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Please mark all conditions that you have or have had:

_____ Arthritis _____ Ulcers of the stomach or bowel

_____ Diabetes _____ Tuberculosis

_____ Asthma _____ High blood pressure

_____ Heart disease _____ Hives

_____ Bleeding problems _____ Blood clots in legs

_____ Hayfever _____ Chronic bronchitis

_____ Emphysema _____ History of mental illness

_____ Kidney disease _____ Valley fever

_____ Other: _____

Are you pregnant? _____ Yes _____ No

Are you on birth control pills? _____ Yes _____ No

Do you smoke? _____ Yes _____ No

Do you have a history of alcohol or substance abuse? _____ Yes _____ No

Have you had skin cancer? _____ Yes _____ No If yes, was it a melanoma?

_____ Yes _____ No

Has anyone in your family had a melanoma? _____ Yes _____ No _____ Not sure

Do you have any medical prosthetics, artificial valves, joints, or a

pacemaker? _____ Yes _____ No

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SIGNATURE OF PROVIDER: _____ DATE: _____