

MEDICAL HISTORY (Please Fill ALL Areas)

PATIENT NAME: LAST: _____ FIRST: _____ MI _____ DATE _____

PRIMARY CARE DOCTOR: _____ MEDICATION ALLERGIES: _____

OCCUPATION: _____ SOCIAL HISTORY: (check one) SINGLE MARRIED WIDOWED

HOW DID YOU FIND OUT ABOUT US? _____

LIST OF MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING ASPIRIN, OVER THE COUNTER MEDS, VITAMINS AND HERBALS: _____

DO YOU HAVE NOW, OR EVER HAD, THE FOLLOWING DISEASES OR CONDITIONS (PLEASE PLACE A CHECK MARK IF APPLICABLE)

- ARTHRITIS
- ARTIFICIAL JOINT
- ASTHMA
- BLADDER DISEASE
- BLOOD CLOTS
- CANCER
- CATARACTS/GLAUCOMA
- EPILEPSY/SEIZURES
- EMOTIONAL/PSYCHIATRIC
- FAINTING

- GASTROINTESTINAL DISORDER
- HEARING LOSS
- HEART ATTACK
- HEART DISEASE
- HEART MURMUR
- HEPATITIS
- HERPES BREAKOUT
- HIGH BLOOD PRESSURE
- HIGH CHOLESTEROL
- HIV POSITIVE / HIV EXPOSURE

- IRREGULAR HEARTBEAT
- KIDNEY DISEASE
- LIVER-GALLBLADDER DISEASE
- MITRAL VALVE PROLAPSE
- PACEMAKER
- POLYCYSTIC OVARIES
- THYROID DISEASE
- TUBERCULOSIS / LUNG DISEASE
- VENEREAL DISEASE

LIST ANY OTHER DISEASES AND CONDITIONS NOT LISTED ABOVE: _____

LIST ANY SURGICAL PROCEDURES YOU HAVE HAD: _____

HAVE YOU EVER HAD SKIN CANCER? YES NO IF YES, PLEASE SPECIFY WHAT KIND AND BODY LOCATIONS: _____

DO YOU DEVELOP SKIN RASHES IN REACTION TO ANY MEDICATIONS, FOOD, OR THE ENVIRONMENT? IF YES PLEASE SPECIFY: _____

DO YOU DRINK ALCOHOL? YES NO IF YES, PLEASE SPECIFY _____

DO YOU USE RECREATIONAL DRUGS? YES NO IF YES, PLEASE SPECIFY _____

DO YOU SMOKE? YES NO IF YES, PLEASE SPECIFY _____

DO YOU HAVE A FAMILY HISTORY OF ECZEMA, LUPUS, RHEUMATOID ARTHRITIS, AUTOIMMUNE DISEASE, THYROID DISEASE, PSORIASIS, OR SKIN CANCER? _____

MENSTRUAL CYCLE: REGULAR / IRREGULAR

ARE YOU PREGNANT OR PLANNING A PREGNANCY? YES

ARE YOU CURRENTLY BREAST FEEDING? YES NO