

Patient Name: _____ Date: _____

Are you allergic to any medications? No Yes **If yes, please list below:**
 1) _____ 2) _____ 3) _____

List all medications you are currently taking (prescriptions, over-the-counter medications, vitamins and herbals):

1. _____ 4. _____ 7. _____
 2. _____ 5. _____ 8. _____
 3. _____ 6. _____ 9. _____

Are you pregnant (women)? Yes No Trying

Chronic Medical Problems:

1. _____ 4. _____
 2. _____ 5. _____
 3. _____ 6. _____

What is your occupation? _____

Do you have now, or have you ever had diseases or conditions of (please check Yes or No):

SKIN Have you ever had skin cancer? Yes No
 Has anyone in your family had skin cancer? Yes No
 Do you have a history of any specific skin disease? Yes No Type: _____
 Do you have problems with healing? Yes No
 Do you develop keloids or thickened scars after surgery? Yes No

	Explain		Explain
LUNGS <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	NEUROLOGIC <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Shortness of breath <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	ARTHRITIS <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
CARDIOVASCULAR <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Artificial Joints <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Joint Pain <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	PSYCHIATRIC <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	OTHER/SYSTEM <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Irregular Heart beat <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Lupus <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Defibrillator <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Artificial Valves <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
GASTROINTESTINAL <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Coumadin/Plavix <input type="checkbox"/> Yes <input type="checkbox"/> No	_____

FAMILY HISTORY

		Relative
Is there a family history of Asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Is there a family history of seasonal allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Is there a family history of hay fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Is there a family history of eczema?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

SOCIAL HISTORY: Check the ones which apply and the amount consumed per day

None Alcohol _____ Tobacco _____ IV Drugs _____

Completed by: Patient Parent / guardian Medical Assistant _____ (initials)

Signature of patient _____

_____ Date

Reviewed by _____

_____ Date