

PATIENT MEDICAL HISTORY

Name: _____ Date: _____

Sex: _____ Age: _____ Occupation (present or most recent): _____

Do you have any allergies to antibiotics or any other medication? Yes No
If so, which medications? _____

Do you suffer from any other allergies? Please list: _____

Please list all medications (including vitamins & herbs) you are currently taking: _____

Do you or have you ever had:

Skin Cancer? Yes No

Any other kind of cancer? Yes No What kind? _____

Diabetes or high blood sugar? Yes No

Hypertension or blood pressure problems? Yes No

Arthritis? Yes No

An artificial joint? Yes No

A heart attack or heart failure? Yes No

Heart rhythm problems, or a pacemaker? Yes No

Asthma? Yes No

Sinus problems or hay fever? Yes No

Chronic bronchitis, emphysema, or other breathing problems? Yes No

Tuberculosis, or a "positive" skin test for tuberculosis? Yes No

Liver problems, hepatitis, or "yellow jaundice"? Yes No

Stomach or bowel problems? Yes No

Kidney problems? Yes No

Glaucoma? Yes No

Migraine headaches? Yes No

Epilepsy — seizures or convulsions? Yes No

Any part of your body paralyzed or numb, or a stroke? Yes No

Thyroid gland problems? Yes No

Any treatment for emotional problems or a "nervous condition"? Yes No

HIV infection? Yes No

Any other health problems? _____ Yes No

Have you ever undergone surgery? Yes No

If so, what kind? _____

When? _____

Do you smoke? Yes No If yes, how often? _____

Do you drink alcohol regularly? Yes No If yes, how often? _____

Has any close family member had asthma, hay fever or allergies? Yes No

Has any close family member had skin cancer? Yes No

If you are a woman: When was your last menstrual period? _____

Are you pregnant? Yes No

Are you using any form of birth control medication? Yes No

Are you nursing? Yes No

For children under 18 years: Are your immunizations up to date? Yes No