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MEDICAL HISTORY

NAME:______________________________ **DATE:**__________

ALLERGIES TO DRUGS OR LATEX(Antibiotics including Penicillin, Pain Medication, Anesthetics, Topical Creams):

____

PRESENT MEDICATIONS(Prescription and Non-Prescription):______________________________

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GENERAL HEALTH: ☐Excellent ☐Good ☐Fair

YES	NO		YES	NO		YES	NO	
☐	☐	Eczema	☐	☐	Skin Cancer	☐	☐	Tuberculosis
☐	☐	Hay Fever	☐	☐	Wound Healing Problems	☐	☐	HIV Disease
☐	☐	Asthma	☐	☐	Thickened Scars	☐	☐	Herpes/Fever Blisters
☐	☐	Hives	☐	☐	Double Jointed	☐	☐	Rheumatic Fever
☐	☐	Food Allergy	☐	☐	Pigmentary Problems	☐	☐	Arthritis
☐	☐	High Blood Pressure	☐	☐	Diabetes	☐	☐	Muscle/Bone Disease
☐	☐	Heart Disease	☐	☐	Thyroid Disease	☐	☐	Joint Replacement
☐	☐	Heart Murmur	☐	☐	Hormone Problems	☐	☐	Glaucoma
☐	☐	Pacemaker	☐	☐	Kidney Disease	☐	☐	Headaches
☐	☐	Implanted Defibrillator	☐	☐	Liver Disease	☐	☐	Fainting/Dizziness
☐	☐	Artificial Heart Valve	☐	☐	Hepatitis/Jaundice	☐	☐	Seizures
☐	☐	Anemia	☐	☐	Breathing Problems	☐	☐	Nervous Problems
☐	☐	Bleeding Problems	☐	☐	Do You Smoke?	☐	☐	Emotional Problems
☐	☐	Stomach/Intestinal Problems	☐	☐	Do You Drink Alcohol?	☐	☐	Hearing Aids

OTHER MEDICAL PROBLEMS (not listed above):______________________________

PREVIOUS SURGERIES:______________________________

PREVIOUS HOSPITALIZATIONS:______________________________

PREVIOUS SKIN PROBLEMS:______________________________

FEMALES: Are You Pregnant? ☐Yes ☐No **Planning to Become Pregnant?**☐Yes ☐No **# of Children**____Ages_____

FAMILY HISTORY: Mother: ☐Living ☐Deceased **Age**_______ **Father:** ☐Living ☐Deceased **Age**_______

Disease	No Family History	Mother	Father	Other Relative
Allergies	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Eczema	☐	☐	☐	☐
Hayfever	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐
Malignant Melanoma	☐	☐	☐	☐
Skin Cancer, Non-melanoma	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐

Hobbies/Leisure Activities:______________________________