Medical History

Patient's Name: _____

Date of Birth _____/_____/_____ **Today's Date** _____/_____/_____

Have you been diagnosed and/or treated for any of these conditions?
(Please Check ALL That Apply)

_____Anemia
_____Anxiety
_____Arthritis
_____Asthma
_____Atrial Fibrillation (Irregular Heart Beat)
_____Blood Clots
_____Cancer, please specify:
_____
_____COPD
_____Coronary Artery Disease
_____Depression
_____Diabetes
_____End Stage Renal Disease
_____GERD
_____ Hepatitis
_____ Hypertension (High Blood Pressure)
_____ HIV / AIDS
_____ Hypercholesterolemia
_____ Kidney Disease (Did it require Dialysis Y or N)
_____ Thyroid Disorder (Hyperthyroid / Hypothyroid)
_____ Lymphoma
_____ Seizures
_____ Stroke
_____ Abnormal Immune System
_____ Heart Attack
_____ Peripheral Vascular Disease
_____ Skin Cancer
_____ Melanoma

Have you received a Blood Transfusion? Y or N
Have you received X-ray Treatments for Acne? Y or N
Have you received Light Treatment for any Kind of Skin Condition? Y or N
Have you received Radiation Treatment for a Cancer? Y or N

Do You? (Please check ALL that apply)

_____ Receive Allergy Shots?
_____ Have a Pacemaker?
_____ Have an Artificial Heart Valve?
_____ Have an Abnormal Heart Valve?
_____ Require Antibiotics Prior to Dental Procedures?
_____ Develop Rashes or Reactions to: Bandages / Tapes / Antibiotic Ointments?
_____ Have Any Organ Transplants?
_____ Have Any Artificial Joints?
_____ Tend to Form Keloid Scars?
_____ Tend to Heal Slowly or Poorly?
_____ Have Varicose Veins?

Do you have any other medical conditions? If yes, please list: _____

_____

Please list all major surgeries: _____

_____

Do you wear sunscreen? Y or N (If so, what SPF?_____)
Do you use a tanning bed/booth? Y or N

Females Only: (if the patient has not undergone changes of puberty, circle n/a) → N/A

Do you develop frequent yeast infections when taking antibiotics? Y or N
Have you had your uterus removed (hysterectomy)? Y or N
Have you had your ovaries removed? Y or N
Are you currently menopausal? Y or N
Have you had one or more miscarriages? Y or N

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❑ *Attention Nurses:* If checked, medications listed below do not include all previous meds listed in EMA. Please review current meds with patient in the room.

Medication History:

Are you allergic to any medications? Y or N If yes, please list: _____

Please list ALL medications you are currently taking (prescriptions, over-the-counter meds, vitamins & herbal supplements):

_____

_____

Do you ever take aspirin, ibuprofen (Motrin, Advil) naproxen sodium (Alleve, Naprosyn), vitamin E supplements, garlic, ginger, gingko or ginseng supplements? If yes, please list the items you do take and describe how often. _____

_____

Have you ever had local anesthesia? Y / N Have you ever had a reaction to local or general anesthesia? Y / N

Family History of Melanoma: Do you have any family members (father, mother siblings or child) with melanoma?

Y or N (if yes, who?) _____

Additional Family History: (Please check ALL that apply to father, mother, siblings, or children)

____ Thyroid Disease	____ Allergies	____ Blood Clots
____ Skin Cancers	____ Asthma	____ Clotting or Bleeding Disorders
____ Eczema	____ Rheumatoid Arthritis	____ Heart Disease or Heart Attack
____ Hair Loss	____ Lupus	____ Stroke
____ Scarring Acne	____ Multiple Miscarriages	____ Diabetes

Social History:

Do you use tobacco products of any kind? (Currently / Formerly / Never) If currently, list type _____

Amount per day _____

Do you drink alcohol? Y or N If yes, how much? (# of drinks per day) _____

Do you or have you ever used recreational drugs? Y or N If yes, what? _____

Route taken? (Oral, IV, nasal, smoke) _____

Have you ever been exposed to HIV or Hepatitis C? Y or N

What is your occupation? _____ Hobbies? _____

When exposed to the sun in the spring *(first significant sun exposure of the warm season*), do you? (Please check one)

____ Burn Only ____ Burn then Tan ____ Tan Only

Review of symptoms: Are you experiencing any of the following symptoms currently or in the last 6 months? (Check ALL that apply)

_____Fevers	____ Excessive Thirst/Hunger	____ Hair Loss
____ Night Sweats	____ Excessive Urination	____ Abnormal Hair Growth
____ Unexplained Weight Gain or Loss	____ Diarrhea	____ Abnormal Sweating
____ Excessive Fatigue	____ Bloody Bowel Movements	____ Excessive Stress
____ Cough	____ Hemorrhoids	____ Recent Increase in Stress Levels
____ Wheezing	____ Abdominal Pain	____ Depressed Mood
____ Shortness of Breath	____ Joint Pain	____ Anxiety
____ Chest Pain	____ Joint Stiffness	Women Only:
____ Fluid Retention	____ Weakness	____ Irregular Menstruation (periods)
____ Leg Swelling	____ Headaches	____ Excessive Bleeding with Menstruation
____ Poor Healing	____ Dizziness	
____ Frequent Infections	____ Vision Changes	
____ Easy Bleeding or Bruising	____ Rashes with Sun Exposure	