

## MEDICAL INFORMATION

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Are you allergic to any medications?    Yes     No     If yes, please list:

\_\_\_\_\_

Are you currently taking any medications: (including aspirin or over the counter products)    Yes     No

If yes, please list: \_\_\_\_\_

\_\_\_\_\_

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pacemaker/Defibrillator	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Bowel Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Phlebitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis or Liver Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Valve Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis/Joint Deformity	Yes <input type="checkbox"/> No <input type="checkbox"/>	Convulsions/Epilepsy/Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>
Fainting	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>

Are you pregnant or nursing?    Yes  No     Are you taking a Birth Control Pill?    Yes  No

Do you have artificial joints?    Yes  No

Do you drink Alcohol?    Heavy     Moderate     Occasional     No

Have you had or have you been exposed to HIV (AIDS)?    Yes  No

Have you ever had dental anesthesia (Novacaine)?    Yes  No     Any bad reaction?    Yes  No

### SKIN:

Have you ever had skin cancer?    Yes  No

Has anyone in your family had melanoma?    Yes  No

Do you have a history of any specific skin diseases?    Yes  No

If yes, please list: \_\_\_\_\_

\_\_\_\_\_

List any other disease or condition we should know about: \_\_\_\_\_

\_\_\_\_\_

List all surgeries: \_\_\_\_\_

\_\_\_\_\_

Completed by:     Patient

Medical Assistant \_\_\_\_\_

Initials

\_\_\_\_\_  
Signed by Physician

\_\_\_\_\_  
Date