

PERSONAL MEDICAL HISTORY

Patient Name: _____ **Date of Birth:** _____

Referring Physician: _____

Reason for Visit: _____

Medication Allergies: Yes No known allergies **If yes, please list below:** _____

List all current prescriptions and over-the-counter medications (not vitamins or supplements):

Do YOU have a history of the following medical problems?

- | | | |
|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Basal Cell Carcinoma |
| <input type="checkbox"/> Cancer (other than skin cancer) | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Squamous Cell Carcinoma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Psychiatric Disease | |

Is there a FAMILY HISTORY of the following medical problems?

- | | |
|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Cancer (other than skin cancer) | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin Cancer (not melanoma) |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Skin Cancer - Melanoma |

SOCIAL HISTORY

Do you drink alcohol? Yes No
Do you smoke? Yes No How long have you smoked? _____

Preferred Pharmacy (example: Fry's, Swan/Grant) _____