



Patient Name: _____ Age: _____ Date of Birth: _____

Referring Doctor: _____

Medication Allergies: _____

Current Medications: _____

Please check any of the following conditions for which you have received treatment (Past Medical History):

____ Diabetes ____ High blood pressure ____ Ulcers ____ Asthma ____ Cancer

____ Other significant medical problems: _____

Family History/Social History:

Marital Status: _____ Number of children: ____ age(s): _____

Check the following conditions that have occurred in your family (parents, children, brothers, sisters)

____ skin cancer ____ melanoma ____ allergies ____ arthritis ____ asthma

____ cancer ____ diabetes ____ eczema ____ hayfever ____ heart disease

____ lung disease ____ psoriasis ____ high blood pressure ____ lupus

(1)Do you drink alcohol? __yes __no (2)Do you smoke? __yes __no (3)Do you use tanning beds? __yes __no

Occupation: _____ Hobbies/leisure activities: _____

Do you have current or past problems with? (Review of systems)

	<u>Yes</u>	<u>No</u>	(if yes, please explain)
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears/Nose/Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach/Bowel	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidneys/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis/muscles/joints	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin (e.g., cancer, eczema)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headache/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychological disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid/Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood/bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	_____
General Health (weight loss, fever, feel ill)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Females Only:

Abnormal menstrual cycle _____

Are you pregnant? Are you planning to become pregnant soon? yes no

Doctor's signature: _____ Date: _____