

**PATIENT HEALTH HISTORY (PAGE 2)**

**MEDICATIONS**  No Medications

Please list all prescribed and over the counter medications you are presently taking:

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**ALLERGIES**  No Allergies

Please list all allergies to medications and other substances: \_\_\_\_\_

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**SURGERIES**  No surgeries

Have you had surgery on any of the following organs?

- Heart       Lungs       Intestine/Stomach  
 Appendix     Joints       Bones  
 Cancer       ovaries     hysterectomy  
 prostate     Other \_\_\_\_\_

**DO YOU HAVE ANY OF THE FOLLOWING?**

YES    NO

- Cardiac pacemaker or defibrillator  
  Take antibiotics for dentist  
  Artificial joint or heart valves  
  HIV+ or AIDS  
  Hepatitis B or C (if yes, which \_\_\_\_\_)  
  History of severe bleeding (nose, surgical)

**PAST MEDICAL HISTORY (SELF, FAMILY)**

Have you or any family members had any of the following?

Self    Family

- Cancer (type) \_\_\_\_\_  
  Thyroid disease  
  High blood pressure  
  Diabetes  
  Tuberculosis (TB)  
  Heart disease, heart attack  
  Blood vessel disease  
  Blood clots  
  Other medical problem not listed above:

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**SKIN HISTORY** Have you had any of the following?

Yes    No

- Personal history of skin cancer  
  Family history of skin cancer  
If yes, what type:  basal cell carcinoma  
                                   squamous cell carcinoma  
                                   melanoma  
                                   unknown  
  Difficulty with wound healing  
  Abnormal scarring  
  Blistering Sunburn  
  Lots of moles  
  History of tanning beds  
  Do you use sunscreen regularly?  
  Do you wear hats in the sun?  
  History of cold sores  
  History of skin infection  
  Radiation exposure

**SOCIAL HISTORY**

Smoking:  cigarettes     pipe     cigar     none

Number of years \_\_\_\_\_ Daily amount \_\_\_\_\_

Alcohol:  beer     wine     other liquors     none

Amount per week: \_\_\_\_\_

Do you use marijuana?     Yes     No

Other recreational drugs     Yes     No

If female, are you or could you be pregnant:

Yes     No

I certify that this history form is filled out completely and accurately. I have answered all questions truthfully and to the best of my knowledge.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date