

Medical History

Patient: _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? YES NO If yes, list: _____

1. _____ 2. _____

List all Medications you are currently taking (please list all meds including over the counter meds, vits, supplements)

1. _____ 3. _____

2. _____ 4. _____

Pharmacy of Choice: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

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

Lungs: YES NO Other Systemic: YES NO

Bronchitis Diabetes

Emphysema Thyroid

Asthma Kidney

Chronic Cough Stomach

Bowel

Hepatitis or Yellow Skin

Glaucoma

Arthritis/Joint Deformity

Convulsions, Epilepsy of Seizures

Fainting

Psychiatric Disorder

Phlebitis

Do you smoke? If Yes, how much? _____

Do you drink alcohol? If YES, _____ drinks per day

Do you use IV drugs? If YES, what? _____ How much? _____

Have you had or have you been exposed to HIV (AIDS)? YES NO

Have you ever had/used Lidocaine? YES NO Any bad reaction? YES NO

List surgical procedures you have had: _____

Skin: Do you have a history of any Keloids or Hypertrophic scarring YES NO

When you are exposed to the sun, do you: Tan only Tan & burn Burn

Have you ever had skin cancer? YES NO

Has anyone in your family had skin cancer? YES NO If yes, who? _____

Basal Cell Squamous Cell

Do you have any personal or family history of Malignant Melanoma YES NO If yes, who? _____

Do you have a history of any specific skin diseases? YES NO

If yes, please list: _____

Any other diseases or conditions we should know about? _____

Please answer the following questions:

A. Do you bleed easily? YES NO

B. (Women) Are you pregnant? YES NO Due Date: _____

C. Do you have artificial joints? YES NO

D. What is your occupation? _____

E. What are your hobbies? _____

Completed by: Patient

Other _____

Name

Signed by Physician

Date