MEDICAL HISTORY

Patient Name: _____Date of Birth: _____

Reason for today's visit: _____Today's Date: _____

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

_____

Are you currently taking any medications or vitamins/mineral supplements? □ Yes □ No

If yes, please list: _____

History of Diseases

Do you have now, or have you ever had diseases or conditions of:

Lungs:	Yes	No
Bronchitis	□	□
Emphysema	□	□
Asthma	□	□
Chronic Cough	□	□
Morning Cough	□	□

Vascular:		
High Blood Pressure	□	□
Chest Pain	□	□
Heart Attack	□	□
Heart Murmur	□	□
Irregular Heartbeat	□	□
Pacemaker	□	□
Phlebitis	□	□

Other Systemic:	Yes	No
Diabetes	□	□
Thyroid	□	□
Kidney	□	□
Bladder	□	□
Stomach	□	□
Bowel	□	□
Hepatitis	□	□
Glaucoma	□	□
Arthritis/Joint Deformity	□	□
Convulsions, Epilepsy or Seizures	□	□
Fainting	□	□

Do you drink alcohol? □ Yes □ No If yes, _____drinks per day/week/month (please circle one)
Do you use IV drugs? □ Yes □ No If yes, what? _____How much? _____
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:

When you are exposed to sun do you: □ Tan Only □ Tan and Burn □ Burn
Have you ever had skin cancer? □ Yes □ No
Has anyone in your family had skin cancer? □ 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 surgical procedures you have had in the last 6 months: _____

Please answer the following questions:

A. Do you smoke? □ Yes □ No If yes, how much: _____
B. Do you bleed easily? □ Yes □ No
C. (Women) Are you pregnant? □ Yes □ No If yes, due date: _____
D. Do you have artificial joint(s)? □ Yes □ No
E. What is your occupation? _____
F. What are your hobbies? _____

Completed by: _____Patient or SID Staff
(Please circle one)

Reviewed by: _____