

Patient Medical History

Patient Name: _____ **DOB:** _____

Do you now, or have you ever had: (circle one)

Heart Disease	Yes	No	Stomach Disorder	Yes	No
High Blood Pressure	Yes	No	Arthritis	Yes	No
Emphysema	Yes	No	Seizure Disorder	Yes	No
Asthma	Yes	No	Eczema	Yes	No
High Cholesterol	Yes	No	Skin Cancer	Yes	No
Diabetes	Yes	No	Allergies,seasonal	Yes	No
Thyroid Disorder	Yes	No	Kidney Disease	Yes	No
Other Cancer (please list below)	Yes	No	Other Skin disorder (please list below)	Yes	No

Other: _____

Have you ever had any surgery? Please list: _____

All Current Medications: _____

Do you have any allergies to any medications? Please list: _____

Has anyone in your family had: (circle one)

Heart Disease	Yes	No	Allergies,seasonal	Yes	No
Diabetes	Yes	No	Asthma	Yes	No
Skin Cancer	Yes	No	Eczema	Yes	No
Other Cancer (please list) _____	Yes	No	Psoriasis	Yes	No

Social History:

Do you drink alcoholic beverages? (circle one) Yes No

If yes, how many drinks a day _____

Smoking: (circle one) Never smoked Previous smoker Current Smoker

(circle one) Cigarettes Cigar Pipe Amount smoked per day _____

I certify that the above information is complete and accurate:

Patient/Parent Signature: _____ Date: _____