Patient Health History Form

Allergies:
□ None
□ Medication Allergies (List Below)

Do you have a Latex Allergy?: □ Yes □ No

Allergy to Adhesive/Band-Aid?: □ Yes □ No

General/Social Information:
Do you use nicotine products? □ Yes □ No
□ Cigarettes □ Cigars □ Pipe □ Ecig □ Gum/patch

Are you a former smoker? □ Yes □No
If yes, when did you quit? _____

Do you drink alcohol? □ Yes □ No

Do you use illicit drugs (cocaine, methamphetamines)? □ Yes □ No

Are you pregnant or nursing? □ Yes □ No

Current Occupation/Employment (Please circle)

Retired Disabled Working as _____

Please List All Current Medications

Prescription Drugs:

Over the counter: (Aspirin, Tylenol, Anti-Histamines like Benadryl, Herbal Supplements, Vitamins)

Please List Current Health/Medical Problems

Please List Previous Surgeries

Review of Systems
Please circle any symptoms below that you feel are affecting your health:

General: Fatigue, unexplained weight gain/loss, fever, chills, night sweats, sleep problems, pain.

Skin: New or changing skin growth, unexplained rash.

Head: Headaches, recent trauma.

Eyes: Blurred/loss of vision, eye pain, discharge, glasses/contacts, dryness

Ears: Excessive noise exposure (loud music), ear pain, loss of hearing, ringing in ears, drainage.

Nose: Frequent bloody nose, sinus pain, post nasal drainage, congestion.

Mouth: Tooth pain, oral sores, bleeding.

Throat: Hoarse voice, voice changes, pain or difficulty swallowing, frequent soreness or swelling.

Neck: Pain, stiffness, swelling.

Chest: Breast changes or lumps, nipple discharge, chest wall pain.

Lungs: Cough, shortness of breath, wheezing

Heart: Murmurs, palpitations, pain with exertion, passing out.

Stomach: Frequent nausea, vomiting, diarrhea, constipation, abdominal pain, bleeding, constipation.

Urinary Tract: Frequent urination, pain on urination, blood in urine.

Musculoskeletal: Joint pain, swelling, muscle pain, stiffness, restricted movement, swelling.

Nervous System: Loss of consciousness, dizziness, seizures, weakness or numbness in any body part, tremors, twitching.

Mental Health: Feelings of nervousness/anxiety/panic, crying spells, depression, confusion, problems concentrating.

Blood/Lymph: Anemia, bleeding tendency, easy bruising, swollen/painful lymph nodes.

Personal/Family Medical History
Please check where you or members of your family, have had the following:

	Father	Mother	Grandparent	Brother(s)	Sister(s)
AIDS/HIV					
Alcoholism					
Anemia					
Anxiety					
Arthritis					
Asthma					
Bleeding Problem					
Cancer					
Cirrhosis					
Dementia					
Depression					
Diabetes Mellitus					
Eczema, Psoriasis					
Eye Problems/Glaucoma					
Heart Disease					
Hemophilia					
High/Low Blood Pressure					
High Cholesterol					
Kidney/Bladder Problem					
Liver Disease/Jaundice					
Lung Disease					
Mental Illness					
Osteoporosis					
Parkinson's Disease					
Peptic Ulcer Disease					
Phlebitis/Blood Clot					
Seizures/Epilepsy					
Stroke					
Thyroid Disease					

Personal History of Skin Cancer? □ Yes □ No

If so, which type? _____

Family History of Skin Cancer? □ Yes □ No

If so, which type? _____

Tanning Bed Use? □ Yes □ No
Sunscreen Use? □ Yes □ No