Health History Form

In order to treat you safely and effectively, please answer the following questions.
This is for our records only and responses are confidential.

Name_____ **Sex**_____ **Age**____ **Birthdate**_____ **Date**_____

Occupation_____

What problem brings you in today? (Chief complaint)_____

Duration: _____ **Have you received treatment in the past:** _____

List prior SURGERIES (write "No" if none):_____

Allergies to medication(s): No Yes (please specify)_____

Medications ("No" if none)**:** _____

_____

If more room needed please us back of page

Do you have a: PACEMAKER Y / N **Are you on: BLOOD THINNERS Y / N**

Do you have any of the following? (Review of Systems) – please circle Y (yes) or N (no)

Recurrent mouth sores	**Y / N**	**Stomach (ie ulcers, acid reflux, pain)**	**Y / N**
Joint Aches	**Y / N**	**Eye problems**	**Y / N**
Leg Swelling (edema)	**Y / N**	**Muscle weakness**	**Y / N**
Depression or Anxiety	**Y / N**	**Kidney Disease (type)**_____	**Y / N**
Bowel problems (type)_____	**Y / N**	**Height and Weight:**_____ **ft** _____**in** _____**lbs**	
Do you Smoke	**Y / N**	**Other** _____	

Past Medical History / Family History- If family history of skin cancer please note relationship

Disease	**Yourself**	**Blood Relative**	**Disease**	**Yourself**
Malignant Melanoma	**Y / N**	**Y / N**	HIV	**Y / N**
Other Skin Cancer			Glaucoma	**Y / N**
Type (Circle) **Basal Cell** **Squamous Cell**	**Y / N**	**Y / N**	Cancer (type)_____	**Y / N**
Abnormal Moles (dysplastic nevi on biopsy)	**Y / N**	**Y / N**	Hepatitis or Liver Problems (type)_____	**Y / N**
Psoriasis	**Y / N**	**Y / N**	High Blood Pressure	**Y / N**
Eczema	**Y / N**	**Y / N**	Elevated cholesterol	**Y / N**
Hives	**Y / N**	**Y / N**	Mitral Valve Prolapse	**Y / N**
Allergies or Hayfever	**Y / N**	**Y / N**	Heart Valve Replacement	**Y / N**
Asthma	**Y / N**	**Y / N**	Joint Replacement	**Y / N**
Thyroid	**Y / N**	**Y / N**	History of Blood Transfusions	
Diabetes	**Y / N**	**Y / N**	Seizures	**Y / N**
Arthritis	**Y / N**	**Y / N**	Pregnant	**Y / N**
			Other_____	

Primary: _____ **Address:** _____

Speacialists: _____

Pharmacy: _____ **Number:**_____

Patient Signature:_____