Health History Form

Reason for Today's Visit: _____

Past Medical History

AIDS/HIV	Yes / No		High Blood Pressure	Yes / No
Arthritis/Joint Deformity	Yes / No		Hepatitis	Yes / No
Asthma	Yes / No		Herpes/Cold Sores	Yes / No
Bleeding/Clotting Disorders	Yes / No		Irregular Heartbeat	Yes / No
Bowels: Abdominal Pain, Nausea, Vomiting, Diarrhea, or Blood in Stool	Yes / No		Kidney Disease	Yes / No
			Liver Disease: Yellowing of Skin, "Clay" Colored Stool or Dark Urine	Yes / No
Chicken Pox	Yes / No		Lupus	Yes / No
Diabetes	Yes / No		Multiple Sclerosis	Yes / No
Eczema or Atopic Dermatitis	Yes / No		Musculoskeletal: Joint Swelling/Pain	Yes / No
Environmental Allergies	Yes / No		Neuro: Confusion or Memory Issues	Yes / No
Fainting	Yes / No		Night Sweats or Fever	Yes / No
Genitourinary: Change in Urination or Blood in Urine	Yes / No		Psoriasis	Yes / No
Gastrointestinal: Abdominal Pain, Nausea, or Vomiting	Yes / No		Psych (Paranoia)	Yes / No
			Respiratory: Chronic Cough	Yes / No
Heart Attack	Yes / No		Seizures	Yes / No
Heart Disease or Chest Pain	Yes / No		Stroke	Yes / No
Heart Murmur	Yes / No		Thyroid Problems	Yes / No
Do you require antibiotics prior to any dental procedures?				Yes / No
Have you ever had a reaction to local anesthesia or Novocain?				Yes / No
Are you currently on blood thinners?				Yes / No
Do you have artificial joints, pacemaker or heart valves? **If yes, where?**				Yes / No
Have you had a positive Tuberculosis test? **If yes, how were you treated?**				Yes / No
Do you bruise in unusual places? **If yes, where?**				Yes / No
(Women Only) Are you or could you be pregnant?				Yes / No

Medical conditions not listed above: _____

Do any of your 1st degree family members have the following? If yes, who?

Seasonal allergies	Yes / No	Who	_____
Asthma	Yes / No	Who	_____
Atopic dermatitis	Yes / No	Who	_____
Psoriasis	Yes / No	Who	_____
Eczema	Yes / No	Who	_____

Social History

Do you have a history of blistering sunburns?	Yes / No			
Do you have a history of tanning bed exposure?	Yes / No			
Do you use alcohol?	Yes / No	Rarely	Socially	Daily
Do you use tobacco?	Yes / No	# Packs/Day	_____	

Cancer History

Do you have a history of cancer?	Yes / No
If yes, what type?	
When was it diagnosed?	
What facility were you treated at?	
What type of treatment did you receive?	

Skin Cancer History

Do you have a history of skin cancer?	Yes / No
Where was it located?	
Who treated it and at what facility?	
Have any immediate relatives had skin cancer?	Yes / No
What type of cancer was it?	

Current Medications & Supplements

Please list current medications & the reason you are taking them

Medication Allergies: Latex, Adhesive, or Special (ex: Nickel or Foods)

Please list any medication allergies

Surgeries

Please list any surgical procedures you have had

Misc.

Primary Care Physician/ Referring Provider & Location:

Pharmacy Name & Location:

(Office Use Only)

Present Illness/Concern

Family History