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MEDICAL HISTORY

Patient Name_____ Date_____

Reason for today's visit_____

Do you have now, or have you ever had diseases or conditions of: *(If yes, please check box)*

Lungs:

[Bronchitis [Emphysema [Asthma [Chronic Cough [Morning Cough

Vascular:

[High Blood Pressure [Chest Pain [Heart Attack [Heart Murmur [Irregular Heartbeat
[Mitral Valve Prolapsed [Pacemaker [Blood Clots/Phlebitis

Other Systemic:

[Diabetes [Thyroid [Kidney [Bladder [Stomach [Bowel [Hepatitis A/B/C
[Glaucoma [Joint/Muscle/Arthritis [Cancer

Current Medication:	Y	N	If yes
Do you have any allergies to food or medicine?	[	[	please list_____
Do you currently use any prophylactic antibiotics?	[	[	If yes, please list_____
Do you drink alcohol?	[	[	If yes, what_____Amt per day_____
Do you currently use IV Drugs?	[	[	If yes, what_____Amt per day_____
Do you currently take any medications?	[	[	If yes, please list_____
Have you ever been exposed to HIV/AID?	[	[	Ever had a blood transfusion? Y[N[
Have you ever had dental anesthesia (Novacaine)?	[	[	Any adverse Reaction? Y[N[
Are you Latex Intolerant?	[	[	

Skin:	Y	N	If yes,
Have you ever had Skin Cancer?	[	[	location(s)_____
Family history of Skin Cancer?	[	[	Relationship:_____
Relationship:_____			Relationship:_____
Do you currently use skin care products?	[	[	If yes, what brand?_____

When exposed to the sun, do you: [Tan [Tan & Burn [Burn

List any other disease or condition we should be aware of: _____

List surgical procedures performed within the last 6 months:_____

Please answer the following questions:	Y	N		Y	N
A. Do you smoke?	[	[	B. Do you bleed easily?	[	[
C. (Woman) Are you pregnant?	[	[	D. Do you have artificial joints, pins or screws?	[	[
If no, date of last menstrual period:_____			E. Do you require antibiotics prior to surgery?	[	[

F. What is your occupation?_____

Completed by: Patient [_____(Initial) Signed by
Nurse [_____(Initial) Physician:_____Date_____
M.A. [_____(Initial)
Reviewed by:_____Date_____

Preferred Pharmacy:_____Pharmacy Telephone Number:_____

Pharmacy Location: _____