

# Medical History Form

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient Email Address \_\_\_\_\_ Phone Number: \_\_\_\_\_

(Your Email Address is kept CONFIDENTIAL - Check box if you do not wish to receive email from our practice )

Primary Care Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_  
(First & Last Name) (First & Last Name)

**Reason for today's visit:** \_\_\_\_\_

## Ethnicity and Race Identification<sup>(1)</sup>:

A. Are you Hispanic or Latino?  Yes  No  
(A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

B. Please select the racial category/ies with which you most closely identify

White  Black/African American  Asian   
Native Hawaiian/Other Pacific Islander  American Indian/Alaska Native

## Skin:

When you are exposed to the sun do you:  Tan only  Tan and Burn  Burn

Have you ever been diagnosed with skin cancer?  Yes  No If yes, what type and when?  
\_\_\_\_\_

Has anyone in your family had skin cancer?  Yes  No If yes, what type and whom?  
\_\_\_\_\_

## Social History:

Do you drink alcohol?  Yes  No If yes, how often?  daily  weekly  occasionally

Do you use IV drugs?  Yes  No If yes, what type and how often? \_\_\_\_\_  
\_\_\_\_\_

Do you smoke?  Yes  No If yes, how much? \_\_\_\_\_

Have you ever been exposed to, had, or currently have HIV (AIDS)?  Yes  No

## Please answer the following questions:

A. Do you bleed easily?  Yes  No

B. Are you pregnant (women)?  Yes  No  Maybe Due Date: \_\_\_\_\_

C. What is your occupation? \_\_\_\_\_

D. What are your hobbies? \_\_\_\_\_

Form Completed by:  Patient  Nurse/MA - Initials: \_\_\_\_\_

(1) Privacy Act Statement: Ethnicity and race information is requested under the authority of 42 U.S.C. Section 2000e-16 and in compliance with the Office Management and Budget's 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. Providing this information is voluntary and has no impact on your treatment, but in the instance of missing information, your medical practice will attempt to identify your race and ethnicity by visual observation. This information is used as necessary to plan for equal treatment opportunity throughout the Federal government. It is also used by the U.S. Office of Personnel Management to locate individuals for personnel research or survey response and in the production of summary descriptive statistics and analytical studies in support of the function for which the records are collected and maintained..

Are you allergic to any medications?  Yes  No If yes, list below:

1. \_\_\_\_\_ 2. \_\_\_\_\_

Have you ever had dental anesthesia (Novocain)?  Yes  No Any bad reaction?  Yes  No

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins and herbal treatments):

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_  
5. \_\_\_\_\_ 6. \_\_\_\_\_

Do you have now, or have you ever had any of the following diseases or conditions?

<b>Lungs:</b>	<b>Yes</b>	<b>No</b>	<b>Other Systemic:</b>	<b>Yes</b>	<b>No</b>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal		
			Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cardiovascular:</b>	<b>Yes</b>	<b>No</b>	Nausea, vomiting, diarrhea when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy, or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>			
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>			

**Skin cont.**

Do you have a history of any other skin disease?  Yes  No If yes, please list below:

Do you develop skin rashes in reaction to:  Medications  Food  The Environment

Please explain: \_\_\_\_\_

List any other diseases or medical conditions: \_\_\_\_\_

List surgical procedures that you have had in the last 6 months: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewer Signature: \_\_\_\_\_ Date: \_\_\_\_\_