

MEDICAL HISTORY

1. Do you have or have you had any of the following conditions?

	Yes	No		Yes	No		Yes	No
Diabetes			High Blood Pressure			Chest Pain		
Asthma			Artificial Joint/ Valve			Pneumonia		
Rheumatic Fever			Immunosuppression			Kidney Disease		
Hepatitis			Emphysema			Cancer		
Glaucoma			Organ Transplant			Stroke		
Seizures			Heart Disease					

Other:

2. List any past illness or surgery for which you were hospitalized.

Operation/Illness	Year
.....	
.....	
.....	

3. List and describe any Allergies to medications and other substances.

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4. List any current medications (include prescription and non prescription drugs).

Medication	Dosage
.....	
.....	
.....	

5. Do you use tobacco? Yes No If yes, how much?

6. Do you use alcohol? Yes No If yes, how much?

7. Have you received a blood transfusion? Yes No If yes, when?.....

8. Have you had a recent weight loss? Yes No If yes, how much?

9. What is the reason for today's visit?

10. Have you received any treatment for skin cancer in the past? Yes No

If yes, type and treatment date.....