MEDICAL HISTORY INFORMATION SHEET

PLEASE CHECK YES OR NO TO EACH OF THE FOLLOWING: DO YOU HAVE A PERSONAL HISTORY OF:

PSORIASIS	( ) YES ( ) NO	GLAUCOMA	( ) YES ( ) NO	LUNG DISEASE	( ) YES ( ) NO
ECZEMA	( ) YES ( ) NO	CATARACTS	( ) YES ( ) NO	STOMACH ULCERS	( ) YES ( ) NO
ACNE	( ) YES ( ) NO	GUM DISEASE/DENTURES	( ) YES ( ) NO	HEPATITIS/LIVER DISEASE	( ) YES ( ) NO
HIVES	( ) YES ( ) NO	HEADACHES	( ) YES ( ) NO	BLADDER PROBLEMS	( ) YES ( ) NO
SKIN CANCER	( ) YES ( ) NO	STROKES	( ) YES ( ) NO	BLOOD IN URINE	( ) YES ( ) NO
ABNORMAL MOLES	( ) YES ( ) NO	EPILEPSY	( ) YES ( ) NO	PROSTATE DISEASE	( ) YES ( ) NO
WEIGHT LOSS	( ) YES ( ) NO	FAINTING/NERVOUSNESS	( ) YES ( ) NO	CANCER	( ) YES ( ) NO
HIGH BLOOD PRESSURE	( ) YES ( ) NO	MITRAL VALVE PROLAPSE	( ) YES ( ) NO	ARTHRITIS/JOINT PAIN	( ) YES ( ) NO
SHORTNESS OF BREATH	( ) YES ( ) NO	THYROID DISEASE	( ) YES ( ) NO	MUSCLE WEAKNESS	( ) YES ( ) NO
SWELLING OF LEGS	( ) YES ( ) NO	DIABETES	( ) YES ( ) NO	PSYCHIATRIC PROBLEMS	( ) YES ( ) NO
CHEST PAIN	( ) YES ( ) NO	ANEMIA/BLOOD DISEASE	( ) YES ( ) NO	ANXIETY	( ) YES ( ) NO
IRREGULAR HEARTBEAT	( ) YES ( ) NO	ASTHMA	( ) YES ( ) NO	HERPES VIRUS	( ) YES ( ) NO
HEART ATTACK	( ) YES ( ) NO	HAY FEVER	( ) YES ( ) NO	HIV POSITIVE/AIDS	( ) YES ( ) NO
RHEUMATIC FEVER	( ) YES ( ) NO	HEARING LOSS	( ) YES ( ) NO	VENEREAL DISEASE	( ) YES ( ) NO

OTHER MEDICAL PROBLEMS (LIST) _____

_____

DO YOU HAVE A PACEMAKER? ( ) YES ( ) NO ARE YOU PREGNANT? ( ) YES ( ) NO

ARE YOU ON BLOOD THINNERS? ( ) YES ( ) NO

ARE YOU ON ANY ARTHRITIS OR PAIN MEDICATIONS? ( ) YES ( ) NO

PLEASE LIST: _____

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING: _____

_____

PLEASE LIST ANY SURGERY(S) YOU HAVE HAD: _____

_____

PLEASE LIST ANY HOSPITALIZATIONS: _____

_____

ARE YOU ALLERGIC TO ANY NUMBING MEDICATIONS? (XYLOCAINE, NOVOCAINE, ETC.) ( ) YES ( ) NO

LIST ANY OTHER DRUG ALLERGIES: _____

DO YOU HAVE A FAMILY HISTORY OF:

ECZEMA	( ) YES ( ) NO	MELANOMA	( ) YES ( ) NO
PSORIASIS	( ) YES ( ) NO	SKIN CANCER	( ) YES ( ) NO
ACNE	( ) YES ( ) NO	SEASONAL ALLERGIES	( ) YES ( ) NO

SOCIAL HISTORY:

OCCUPATION: _____

DO YOU:

CONSUME ALCOHOL? ( ) YES ( ) NO OUNCES PER WEEK _____

SMOKE CIGARETTES? ( ) YES ( ) NO PACKS PER DAY _____ NUMBER OF YEARS _____

DO YOU WEAR SUNSCREEN? ( ) YES ( ) NO

DO YOU HAVE AN ALLERGY TO LATEX ( ) YES ( ) NO

I offer a full skin examination to my patients to check for suspicious skin lesions. Please let me know if you wish to take advantage of this examination as I will need you to disrobe and put on a gown prior to seeing me. ( ) Yes ( ) No Thank You.

Patient Signature _____ Date _____