

## Past Medical and Family History

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Who is your Primary/General Care Physician? \_\_\_\_\_

How did you hear about our office?  Physician (Whom) \_\_\_\_\_

Family/Friend \_\_\_\_\_  Insurance  Yellow Pages  Other \_\_\_\_\_

Please list your current medications.

1. \_\_\_\_\_ 5. \_\_\_\_\_
2. \_\_\_\_\_ 6. \_\_\_\_\_
3. \_\_\_\_\_ 7. \_\_\_\_\_
4. \_\_\_\_\_ 8. \_\_\_\_\_

Do you have any known drug allergies? Yes No If Yes, which drug(s).

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

Do you or your blood relatives have any history of the following?

	You	Relative		You	Relative
<b>Skin</b>			<b>Psychiatric</b>		
Melanoma Skin Cancer			Depression		
Basal Cell Skin Cancer			Suicide Attempt/Thoughts		
Squamous Cell Skin Cancer			Bipolar Disorder		
Psoriasis			Schizophrenia		
Eczema			Anxiety Disorder		
<b>Other</b>			<b>Neurological</b>		
<b>Rheumatologic</b>			Stroke		
Lupus			Seizures		
Arthritis			Multiple Sclerosis		
Other			Parkinson's Disease		
<b>Hematologic/Lymphatic</b>			Other		
Bleeding Disorder			<b>Endocrine</b>		
Lymphoma/Leukemia			Diabetes		
Sickle Cell			Thyroid Disorder		
G6PD Deficiency			Other		
Anemia			<b>Gastrointestinal</b>		
Other			Ulcer		
<b>Cardiovascular</b>			Liver Disorder		
Congestive Heart Failure			Colitis		
Hypertension			<b>Breast</b>		
Irregular Heartbeat			Cystic Breast		
Pacemaker			<b>Musculoskeletal</b>		
Chest Pain			Arthritis		
Other			Artificial Joint		
<b>Respiratory</b>			<b>Infectious</b>		
Asthma			Hepatitis (A, B, or C)		
COPD/Emphysema			HIV		
Hay fever			Syphilis		
Other			Sexually Transmitted Disease		

**Please answer the following questions:**

When you are exposed to the sun do you: Tan Tan & Burn Burn

Do you routinely take aspirin? Yes No

List any other disease or condition we should know about. \_\_\_\_\_

List surgical procedures you have had in the past 12 months. \_\_\_\_\_

Marital Status: S M D W Do you smoke? Yes No (Women) Are you pregnant? Yes No

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed By

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date