

Medical History

Patient: _____ Date: _____

Reason for today's visit: _____ Referred by: _____
Primary Care Physician: _____

Are you allergic to any medications: YES NO If yes, list:
1. _____ 2. _____

Do you have now, or have you ever had diseases or conditions of : (Please check YES or NO)

<u>Lungs:</u>	YES	NO		<u>Other Systemic:</u>	YES	NO	
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Kidney	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>		Bladder	<input type="checkbox"/>	<input type="checkbox"/>	
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>		Stomach	<input type="checkbox"/>	<input type="checkbox"/>	
Pulmonary Embolus	<input type="checkbox"/>	<input type="checkbox"/>	_____ Date	Bowel	<input type="checkbox"/>	<input type="checkbox"/>	
<u>Vascular:</u>				Hepatitis or Yellow Skin	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiologist Name & Phone #:				Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>	
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>		Convulsions,Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____ Date	or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>		Fainting	<input type="checkbox"/>	<input type="checkbox"/>	
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>		Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____ Date
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>		Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>	
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>		Brain or Spine Stimulator	<input type="checkbox"/>	<input type="checkbox"/>	
Bypass Surgery	<input type="checkbox"/>	<input type="checkbox"/>		Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	_____ CBC Plat
Deep Venous Thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	_____ Date	Height _____ Weight _____			30 day
Do you drink alcohol?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES _____ drinks per day	(weight is used to calculate medication dosage)			
Do you use IV drugs?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, what? _____ How much? _____				
Have you had or have you been exposed to HIV (AIDS)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO					
Have you ever had dental anesthesia (Novacaine)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Any bad reaction?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		

Skin:

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

Have you ever had skin cancer? YES NO If YES, What type? _____

Do you have a history of skin infection? YES NO ___Rx: Doxy 100 mg BID & Bactroban intranasal BID

Do you have a history of cold sores? YES NO ___Rx: Valtrex 500 mg PO BID 1 day before X7 days

Has anyone in your family had skin cancer? YES NO If YES, Who? _____

Do any of your first-degree relatives have a severe drug reaction to medication? YES NO If YES, Name of medication? _____

Do you have a history of any specific skin diseases? YES NO

If YES, please list _____

List any other disease or condition we should know about: _____

List surgical procedures you have had in the last 6 months: _____

Please answer the following questions:

A. Do you smoke? YES NO If YES, how much: _____

B. Do you bleed easily? YES NO

C. (Women) Are you pregnant or nursing? YES NO Due Date: _____

D. Do you have artificial joints, valves? YES NO

E. What is your occupation? _____ H/O endocarditis YES NO

F. What are your hobbies? _____ Premed prior to dentist YES NO

G. Are you claustrophobic? YES NO

OFFICE USE ONLY:

<input type="checkbox"/> All. AntiB.	<input type="checkbox"/> Bloodthinners	<input type="checkbox"/> Tobacco use
<input type="checkbox"/> All. Anesth	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Hepatitis, HIV
<input type="checkbox"/> Cardiac HX	<input type="checkbox"/> Artif. Joint or Valve	<input type="checkbox"/> DM, Immunosup

Keflex 2 gm 1hr prior
Clindamycin 600mg 1 hr prior
Amoxicillin 2 gm 1 hr prior

Patient
 Medical Assistant _____ (Initials)

Signed by Physician Date

Reviewed by Date