

Patient Name _____ DOB _____

Medication Allergies? _____

LIST OF CURRENT MEDICATIONS (OTC and prescription) Reason for Medication

MEDICAL CONDITIONS KNOWN TO PATIENT:

1.
2.
3.

HAVE YOU EVER BEEN HOSPITALIZED? IF YES, PLEASE LIST DATES AND PROBLEMS)

Year	Problem / Surgery	Hospital	Physician

DO YOU HAVE A HISTORY OF:	Yes	No
Asthma		
Dermatitis		
Eczema		
Hepatitis C		
Herpes		
HIV/AIDS		
Hyperthyroid		
Hypothyroid		
Liver disease		
Lupus		
Melanoma		
Murmur		
Psoriasis		
Skin Cancer		
Tinea (skin/foot fungus)		
Warts		

DO YOU HAVE:	Yes	No
Adhesive Allergy		
Advanced directive (Health Care Proxy)		
Bowel or Urination changes		
Changing moles-color, size, bleeding		
Chills		
Cough		
Depression		
Difficulty sleeping		
Difficulty with hearing		
Fevers		
Hair loss or nail changes		
Headaches		
Immunizations up to date?		
Latex allergies		
Muscle or joint aches		
Recent stress		
Sensitive skin		
Unexplained weight gain or loss		
Vision Problems		

DOES ANYONE IN YOUR FAMILY HAVE HISTORY OF:	Yes	No
Allergies		
Asthma		
Cancer		
Cancer of the Skin		
Dermatitis		
Eczema		
Melanoma		
Psoriasis		

Personal Habits

Alcohol (amount per day/week)
Coffee, Cola (amount per day?)
Laundry detergent brand?
Dryer sheets?
Pets (what kind?)
Soap (brand)?
Suntan Parlors (frequency)
Smoking (amount per day, how many years?)