

PATIENT HISTORY FORM

NAME:		DATE:	
Past Medical History			
Have you or members of your family had any of the following:	You	Your Family	List present medications you are taking: (Including herbal and vitamin supplements)
Abnormal Bleeding			
Acne			
Anemia			
Arthritis			
Asthma			
Blood Clots			
Cancer			
Cold Sores			
Diabetes			
Eczema			
Gall Bladder Disease			
Heart Disease			
Hepatitis			
High/Low Blood Pressure			Personal Alcohol History:
High Cholesterol			Age Started:
HIV			Age Stopped:
Liver Disease			Quantity:
Melanoma			
Nervous Disorders			Personal Smoking History:
Psoriasis			Age Started:
Skin Cancer			Age Stopped:
Thyroid Disease			Quantity:
Tuberculosis			Cigarettes Pipe Cigars
Allergies	Yes	Reaction	What other Physicians are you currently seeing:
Latex			
Penicillin			
Local Anesthetic			
List any other relevant allergies that you are aware of:			