MEDICAL HISTORY

Patient's Name: ______________________________ **Date:** __________

Are you allergic to any medications? ☐Yes ☐No *If yes, please list* ____________
Have you had any allergic reaction requiring an emergency room visit? __________
Do you get dizzy when you give blood or when getting an injection? ☐Yes ☐No
Have you had any reaction to local anesthesia? ☐Yes ☐No *If yes, explain* ____________
Do you require antibiotics prior to any surgeries? ☐Yes ☐No
Do you take aspirin, fish oils, or blood thinners daily? ☐Yes ☐No
Who is your Primary Care Physician? *List Name, Address & Phone #:* ____________

Do you have now, or have ever had diseases or conditions of: *(please check yes or no)*?

Yes	No	**SKIN**
☐	☐	Skin Cancer ____________
☐	☐	Bleed easily
☐	☐	Keloids scars
☐	☐	Slow in healing
☐	☐	Latex sensitive
☐	☐	Hives/itchy skin
☐	☐	Blistering sunburns
☐	☐	Develop rashes in reaction to: ☐ *Medications* ☐*Food* ☐*Environment* ☐*Bandaids/Tape* Explain: ____________
☐	☐	Other ____________
		INFECTIONS
☐	☐	Fever blisters
☐	☐	Herpes, location ____________
☐	☐	Shingles
☐	☐	Chickenpox
☐	☐	Hepatitis (circle type: A, B, C, unknown, non-infectious)
☐	☐	Tuberculosis
☐	☐	HIV
		EARS/NOSE/THROAT
☐	☐	Cold sores
		RESPIRATORY
☐	☐	Asthma
☐	☐	Emphysema
		CARDIOVASCULAR
☐	☐	High blood pressure
☐	☐	Irregular heartbeat
☐	☐	Heart attack
☐	☐	Heart murmur
☐	☐	Cardiac surgery
☐	☐	Stent
☐	☐	Mitral valve prolapse
☐	☐	Artificial heart valve
☐	☐	Pacemaker
		GASTROINTESTIONAL
☐	☐	Liver disease/Hepatitis
☐	☐	Ulcers

YES	NO	**GENITOURINARY**
☐	☐	Are you pregnant?
☐	☐	Are you planning pregnancy?
☐	☐	Are you breastfeeding?
		MUSCULOSKELETAL
☐	☐	Rheumatoid arthritis
☐	☐	Lupus
☐	☐	Neuromuscular disease (MS, etc.)
☐	☐	Artificial joints ____________
		NEUROLOGIC
☐	☐	Fainting or loss of consciousness
☐	☐	Seizures/Convulsions/Epilepsy Explain ____________
☐	☐	Migraine/frequent headaches
		HEMATOLOGIC
☐	☐	Phlebitis/painful veins
☐	☐	Blood clots
		ENDOCRINE
☐	☐	Diabetes mellitus
☐	☐	Thyroid disease, type ________
		PSYCHIATRIC
☐	☐	Depression (present or past)
		MALIGNANCY
☐	☐	Cancer What Type ____________ When ____________
		SOCIAL
☐	☐	Do you smoke?
☐	☐	Do you drink alcohol? How much? ____day ____week

Please list all other surgeries (give dates) or medical conditions:

____

____

Signature of Patient: ______________________________ Date: __________
Questionnaire reviewed by: ______________________________