

HEALTH HISTORY

Patient Name _____ Birth Date _____ Date _____

Past Medical History

Have You ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Pneumonia	No	Yes	Diabetes	No	Yes	AIDS or HIV+	No	Yes
Rheumatic fever	No	Yes	Cancer	No	Yes	Mitral valve prolapse	No	Yes
Heart disease	No	Yes	Stroke	No	Yes	Blood transfusion	No	Yes
Arthritis	No	Yes	Hepatitis	No	Yes	High blood pressure	No	Yes
Venerreal disease	No	Yes	Thyroid disease	No	Yes	Low blood pressure	No	Yes
Anemia	No	Yes	Asthma	No	Yes	Kidney disease	No	Yes
Tuberculosis	No	Yes	Hives/Eczema	No	Yes	Bleeding tendency	No	Yes

Do you have a past history of skin cancer: No Yes

If yes, what type: Melanoma, Basal Cell, Squamous Cell, Other _____

Do you have a **family history** of melanoma or skin cancer: No Yes

Do you have any allergies: Drug, Food, Other _____

Previous Hospitalizations/Surgeries/Serious Illnesses _____

Medications (Include nonprescription) _____

Patient Social History

Use of alcohol	Never	Rarely	Moderately	Daily
Use of tobacco	Never	Previously, but quit	Current packs/day	_____
Use of drugs	Never	Type/Frequency	_____	_____

Patient Medical History

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Children	_____	_____	_____

Have you been experiencing any of the following?

Sore throat	No	Yes	Unexplained weight loss	No	Yes	Severe or persistent headache	No	Yes
Cough	No	Yes	Changes in bowel habits	No	Yes	Dizziness, numbness, tingling	No	Yes
Fevers	No	Yes	Blood in stool	No	Yes	Debilitating fatigue	No	Yes
Palpitations	No	Yes	Bleeding problems	No	Yes	Depression	No	Yes
Chest pain	No	Yes	Shortness of breath	No	Yes	Hearing problems	No	Yes
New bone pain	No	Yes	Frequent urination	No	Yes	Swelling or tenderness in neck, armpit, groin	No	Yes

Do you have any artificial parts? _____ Do you take an antibiotic before going to dentist? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of patient/parent/guardian _____ Date _____ Signature of doctor _____ Date _____