MEDICAL HISTORY RECORD

Name _____
Height _____Weight _____Age _____Date _____
Reason for Visit _____
Referred By _____Family Doctor _____
Date Symptoms First Appeared _____

PERSONAL HISTORY: (Circle Yes or No)
Yes No Do you smoke? _____ packs a day
PREVIOUS SURGERIES: _____
_____
_____

SCARRING: Yes No Have you formed keloids excessive or unsatisfactory scars in the past?

PERSONAL MEDICAL HISTORY: (Circle Yes or No)

Yes	No	High blood pressure	Yes	No	Ulcer disease or abdominal problem
Yes	No	Heart disease or attack	Yes	No	Hepatitis
Yes	No	Heart Murmur or disorder	Yes	No	Diabetes
Yes	No	Chest pain or shortness or breath	Yes	No	Other significant illness. If so, describe:
Yes	No	Stroke			_____
Yes	No	Prolonged bleeding, excessive bruising			_____
Yes	No	Fainting or blackout episodes			_____

CURRENT MEDICATIONS: List all, including aspirin, birth control, over-the-counter

Medication	Dose / Strength	Frequency Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DIETARY SUPPLEMENTS: Vitamins, herbs, natural health supplements

Medication	Dose / Strength	Frequency Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES: Allergic medications, reactions to medications, drugs, or local anesthesia

Medication	Reaction when taken last
_____	_____
_____	_____
_____	_____

FAMILY HISTORY: Is there a history of the following in your immediate family? If so please list the family member beside the disease.

Yes	No	Any anesthetic problems_____	Yes	No	Hepatitis_____
Yes	No	High blood pressure_____	Yes	No	Heart attack_____
Yes	No	Diabetes_____	Yes	No	Cancer (skin)_____
Yes	No	Any bleeding problems (hemophilia) ____	Yes	No	Stroke_____
		_____	Yes	No	Other Cancers (type)_____

1. We may take photographs. They could be used for teaching purposes. We would like your permission to do this.

_____ _____
(Date) (Signature)

2. To my knowledge the above information is complete and accurate

_____ _____
(Date) (Signature)