Patient History

DATE_____

PATIENT NAME_____
FIRST **MIDDLE** **LAST**

OCCUPATION_____

SOCIAL HISTORY: DO YOU SMOKE? YES OR NO DO YOU DRINK? YES OR NO

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE:

DIABETES	_____	**AIDS**	_____
HIGH BLOOD PRESSURE	_____	**PREGNANT**	_____
BLEEDING DISORDER	_____	**HEART CONDITIONS**	_____
HEART MURMUR	_____	**HAYFEVER**	_____
HEPATITIS	_____	**VARICOSE VEINS**	_____
PEPTIC ULCERS	_____	**ANEMIA**	_____
HIVES	_____	**ECZEMA**	_____
PSORIASIS	_____	**KELOIDS**	_____
PACEMAKER	_____	**CANCER (_____)**	_____

ANY OTHER CONDITION NOT SPECIFIED_____

DO ANY OF YOUR FAMILY MEMBERS HAVE ANY OF THE ABOVE CONDITIONS? YES/NO

IF SO, WHAT MEMBER AND WHICH CONDITION?_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES OR NO

IF SO, WHICH ONES?_____

LIST ALL CURRENT MEDICATIONS YOU ARE TAKING?_____

_____

_____

_____

OFFICE STAFF INITIALS: _____