

Medical History

Name _____ Date _____

Height _____ Weight _____

Reason For Today's Visit _____

Any Skin Diseases _____

Current Medications _____

Allergies To Medicine _____

Operations _____

Family History Of Illness _____

PLEASE CHECK ALL THAT APPLY

Do You: Smoke Drink Alcohol Special Diet Exercise Routinely

PLEASE CHECK IF YOU HAVE THE FOLLOWING:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Peptic Ulcer | <input type="checkbox"/> Ulcer Colitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pernicious Anemia | <input type="checkbox"/> Other Illnesses |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pregnant | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV + | <input type="checkbox"/> Rheumatoid Arthritis | _____ |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Kidney | <input type="checkbox"/> Thyroid | |
| <input type="checkbox"/> Diabetes
Type _____ | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nail Disorder | <input type="checkbox"/> Ulcers | |