**PAST MEDICAL HISTORY FORM- Complete Every 6 Months** ▢NO CHANGE

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Please list all medications that you are currently taking. ▢ No medications

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Are you allergic to any medication? Please list. ▢ No allergies

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Have you had the flu vaccine this season? **▢ Yes ▢ No**

**Medical History (**Select any of the following medical conditions that you currently have)

* Anxiety
* Arthritis
* Asthma
* Depression
* Diabetes
* Hearing Loss
* Hepatitis Type: \_\_\_\_\_\_\_
* High Cholesterol
* High Blood Pressure
* Hyperthyroidism
* Hypothyroidism
* Seizures
* Stroke
* Problems with bleeding
* Problems with healing
* Hay fever/other allergies
* Immunosuppression
* Headaches
* Heart problems
* Pregnant
* Kidney/urinary problems
* Artificial Joints(specify joint/year): \_\_\_\_\_\_\_\_\_\_\_
* Shortness of breath
* Heart Attack
* Defibrillator
* Pacemaker
* Implantable Devices
* Other Cancer (Not of Skin): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other (List below) \_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin Cancer:**

* Basal Cell Carcinoma
* Squamous Cell Carcinoma
* Melanoma

**Family history of:**

**Melanoma:** ▢ Yes ▢ No **Relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Non-Melanoma skin cancer:** ▢ Yes ▢ No **Relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social History:** (These are government required questions)

1. If you are 18 years or older, how many times in the past year have you had 5 or more alcoholic drinks in a day for men, or 4 or more alcoholic drinks in a day for women? ▢ None or 1 ▢ 2 or more
2. Do you smoke? ▢ Yes ▢ No ▢ Former/Quit

**For Patients 65 years of age and older:**

Do you have a living will/ advance medical directive? ▢ Yes ▢ No

Have you had a pneumonia vaccine in the past 5 years ▢ Yes ▢ No

**For patients 19 years old and under*,* please provide the following:**

Height: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Weight: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**