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: _____