

# MEDICAL HISTORY RECORD

Name \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Reason for Visit \_\_\_\_\_  
Referred By \_\_\_\_\_ Family Doctor \_\_\_\_\_

Date Symptoms Appeared \_\_\_\_\_

**PERSONAL HISTORY:** *(Circle Yes or No)*

Yes No Do you smoke? \_\_\_\_\_ packs per 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	Fainting or blackout episodes
Yes	No	Heart disease or attack	Yes	No	Ulcer disease or abdominal problem
Yes	No	Heart murmur or disorder	Yes	No	Hepatitis
Yes	No	Chest pain or shortness of breath	Yes	No	Diabetes
Yes	No	Stroke	Yes	No	Other significant illness. If so, describe:
Yes	No	Prolonged bleeding, excessive bruising			

**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 last taken
_____	_____
_____	_____

**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 ( <i>skin</i> )
Yes	No	Any bleeding problems ( <i>Hemophilia</i> )	Yes	No	Stroke
			Yes	No	Other cancers ( <i>type</i> )

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

(Date) \_\_\_\_\_ (Signature) \_\_\_\_\_

To my knowledge the above information is complete and accurate.

(Date) \_\_\_\_\_ (Signature) \_\_\_\_\_