Medical History

Patient Name: _____ Date: _____

Are you allergic to any medications? No Yes (if yes, please list)

1. **1.**
2. _____
3. _____
4. _____
5. _____

List all medications you are currently taking (including prescriptions, over the counter medications, vitamins and herbs)

1. **1.**
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

Chronic Medical Conditions:

1. **1.**
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

Past Surgical Procedures:

1.
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Social History:

1. **Do you drink alcohol? No Yes If yes, how many drinks/day or week _____**
2. **Do you smoke? No Previous Quit (year) _____ Yes If yes, what _____**
3. **Have you had or been exposed to HIV? No Yes**
4. **History of skin cancer? No Yes (type)_____**
5. **Family history of skin cancer? No Yes (who, type) _____**

What is your occupation? _____

Completed by: patient parent/guardian spouse other _____(relationship)