

## Medical Information and History

Phone (817) 921-2838

Patient Name \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Information:** *(please complete this section in its entirety)*

Reason for your visit? \_\_\_\_\_

When did this start? When did you first notice? \_\_\_\_\_

Are you allergic to any medications?  Yes  No

If yes, list medication to which you are allergic: \_\_\_\_\_

List all medication you are currently taking: \_\_\_\_\_

List all operations/surgeries you have had: \_\_\_\_\_

Are you scheduled for any upcoming surgeries?

If yes, list surgery and expected date: \_\_\_\_\_

**Medical History** *(please circle each condition or disorder that applies to you)*

<b>Acne</b>	<b>Glaucoma</b>	<b>Malignant Melanoma</b>
<b>Anemia</b>	<b>Hair Loss</b>	<b>Mitral Valve Prolapse</b>
<b>Arthritis</b>	<b>Hay Fever</b>	<b>Neurological Problems</b>
<b>Asthma</b>	<b>Headaches (chronic)</b>	<b>Psoriasis</b>
<b>Bleeding (excessive)</b>	<b>Heart Problems</b>	<b>Rheumatic Fever</b>
<b>Blood Clots</b>	<b>Hepatitis</b>	<b>Pacemaker</b>
<b>Breathing Disorder</b>	<b>Herpes Simplex (cold sores)</b>	<b>Scarring/Keloids</b>
<b>Bruise Easily</b>	<b>Herpes Zoster (shingles)</b>	<b>Skin Cancer</b>
<b>Cancer</b>	<b>High Blood Pressure</b>	<b>STD/Venereal Diseases</b>
<b>Cataracts</b>	<b>HIV</b>	<b>Stroke</b>
<b>Colon/Intestinal Disorders</b>	<b>Hives</b>	<b>Thyroid Disease</b>
<b>Convulsions/Seizures</b>	<b>Infections (chronic)</b>	<b>Tuberculosis</b>
<b>Depression</b>	<b>Kidney Disease</b>	<b>Ulcers</b>
<b>Diabetes</b>	<b>Liver Disease</b>	<b>Varicose Veins</b>
<b>Eczema</b>	<b>Loss of Skin Pigment</b>	<b>Vitiligo</b>
<b>Epilepsy</b>	<b>Lung Disease</b>	<b>Warts</b>
<b>Fainting Spells</b>	<b>Lupus</b>	<b>Wound Healing Difficulty</b>

Other Conditions: *(please list/explain)* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_