Health History Form

Name: _____ **Gender:**_____ **Birthdate:**_____

Insurance Carrier: _____

Ethnicitiy: __Hispanic or Latino/a __Not Hispanic or Latino/a __Choose not to specify

Race: __American Indian/Alaskan Native __Asian __ Black/African American __Native Hawaiian __ White/Caucasian

Preferred Language: _____

Martial Status: ___Single ___Married ___Divorced ___Widowed

YOUR past medical history:

Y/N Cancer (other than skin) _____
Y/N Diabetes (specify type) _____
Y/N Gastrointestinal Illness
Y/N Hepatitis (specify type) _____
Y/N HIV
Y/N Pacemaker/Defibrillator
Y/N Thyroid Disorder
Y/N Tuberculosis

History of skin cancer:

Y/N Personal history of skin cancer
Y/N Personal history Melanoma
Y/N Family history of skin cancer or melanoma?
Y/N Have you ever used a tanning bed? If yes, how often_____
Y/N Do you wear sunscreen consistently?

Allergies: _____

Medications/supplements/birth control: _____

Do you have allergies or reactions to: ___Rubber/Latex ___Eggs ___Milk ___Local Anesthetics ___Epinephrine ___Topical antibiotics (eg. Neosporin) ___Surgical tape/bandages

Primary Pharmacy (Name and location): _____

Y/N Flu Vaccine: If yes, please list the date_____
Y/N Pneumonia Vaccine: If yes, please list the date_____
Y/N Do you drink alcohol: If yes, occasionally or daily?
Y/N Do you drink caffeine: If yes, how many servings? _____
Y/N Do you smoke, use tobacco, or have a history of either?

FAMILY(blood relatives) medical health history:

Y/N Adopted
Y/N Arthritis
Y/N Autoimmune disorder
Y/N Diabetes
Y/N Hayfever, asthma, allergies

List Prior Surgeries (including cosmetic surgeries, write "no" if none):

_____

If you are female, are you:

Y/N Pregnant
Y/N Attempting pregnancy
Y/N Breastfeeding
Y/N Not actively preventing pregnancy
Y/N Birth Control (specify type): _____