

Patient Name: _____ Date of Birth _____

Check box if you have or had the following medical conditions

Respiratory

- Bronchitis
- Emphysema
- Asthma
- Chronic/morning cough
- Shortness of breath
- Wheezing
- Seasonal allergies

Cardiovascular

- High blood pressure
- Chest pain
- Heart attack
- Heart murmur
- Irregular heartbeat
- Phlebitis
- Inflammation of vein
- Blood clots
- Stroke
- Pacemaker
- Defibrillator
- Congestive heart failure

Women

- Breast cancer
- Right mastectomy
- Left mastectomy
- Pregnant Due Date _____
- Breast feeding
- Hysterectomy
- Tubal ligation

Skin

- Skin cancers
- Melanoma
- Precancer/actinic keratosis
- Problems healing
- Bleed easily
- Diaper rash
- Hand rashes
- Eczema/dermatitis
- Psoriasis
- Acne
- Rosacea

Other

- Diabetes
- Excessive thirst/hunger
- Thyroid disease
- Kidney disease
- Bladder problems
 - Frequency/burning
- Yeast infection when taking antibiotics
- Arthritis/joint deformity
- Painful joints
- Limited motion
- Artificial joint
- Convulsions, epilepsy or seizures
- Fainting
- Glaucoma
- Hepatitis/yellow jaundice
- Gastrointestinal disease
- Stomach absorptive disease
- Nausea, vomiting, diarrhea when taking antibiotics
- Stomach ulcers
- AIDS/HIV exposure
- Blood transfusions
- Depression
- Multiple Sclerosis
- Mental disorder
- Instructed to take antibiotics prior to surgical procedures

- Surgical procedures in past 6 months

- Other disease or conditions

Family History

- Skin cancer
- Melanoma
- Abnormal moles
- Keloids

Review of Systems

- New or recent change in moles
- Trouble taking oral antibiotics
- Enlarged lymph nodes
- Immune system problems
- Rash to bandages or tape
- Rash from oral antibiotics
- Rash from antibiotic ointment

Please check this box if the above do not apply