



**PATIENT HEALTH INFORMATION**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Do you have a history of: (Please check any that apply)

- |                                   |  |  |
|-----------------------------------|--|--|
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Hayfever            | <input type="checkbox"/> Jaundice          |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Condition     | <input type="checkbox"/> Stomach Ulcer     |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis      |

Do you have a family history of: (Please check any that apply)

- |                                   |   |
|-----------------------------------|---|
| <input type="checkbox"/> Melanoma | <input type="checkbox"/> Skin Cancer (Ex: Basal or Squamous Cell Carcinoma) |
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Please list all medications you are currently taking orally (by mouth) or include a copy:

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Please list any medications used in the past that pertain to today's visit:

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Please list any allergies to medications:

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