2226 Liliha Street, Suite 302, Honolulu, HI 96817

Medical History Form

Name: ____ Date of Birth: ____

Preferred Pharmacy: ____

Reason for Visit: ____

Past Medical History and Review of Symptoms:

Please check ALL of the following that you currently have or have had in the past.

Cardiovascular
- ☐ Heart Attack / Chest pain
- ☐ Valve Problem / Murmur
- ☐ Prosthetic valve / Pacemaker
- ☐ High blood pressure
- ☐ Irregular heart rhythm
- ☐ Peripheral vascular disease

Respiratory
- ☐ COPD / Emphysema
- ☐ Asthma
- ☐ Oxygen Use: ________Liters
- ☐ Cough

Neurological
- ☐ Seizure / Epilepsy
- ☐ Stroke / Paralysis
- ☐ Nerve Pain / Neuralgia
- ☐ Numbness / Tingling

Endocrine
- ☐ Diabetes
- ☐ Thyroid

Musculoskeletal
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Artificial Joints:

Which Joint: ________________
Date: ______________________

Gastrointestinal
- ☐ Hepatitis
- ☐ Liver Disease / Jaundice
- ☐ Stomach Ulcers

Genitourinary
- ☐ Dialysis
- ☐ Kidney Disease
- ☐ Genital problems

Autoimmune
- ☐ Lupus
- ☐ Rheumatoid arthritis
- ☐ Other: ____________

Infections
- ☐ HIV / AIDS
- ☐ Tuberculosis
- ☐ Hepatitis B or C

Ear/Nose/Throat
- ☐ Cataracts / Glaucoma
- ☐ Hearing Aids
- ☐ Other: _______________

Psychiatric
- ☐ Depression / Anxiety
- ☐ Dementia
- ☐ Other: _______________

Transplants:

Location:____________
____
Date: _______________

Major Surgeries: ____

Skin History:

- ☐ Basal cell carcinoma
- ☐ Squamous cell carcinoma
- ☐ Melanoma
- ☐ Pre-cancer (Actinic Keratosis)
- ☐ Atypical/Dysplastic Moles
- ☐ Abnormal Scars/Keloids
- ☐ Tanning bed use
- ☐ Blistering sunburns
- ☐ History of Rashes
- ☐ Family history of skin cancer

List All Medications and Doses: (Attach additional sheet if necessary)

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Allergies

List ALL allergies to medications:	Reaction:

Allergic to tape or adhesives? ☐ Yes ☐ No
Allergic to anesthetic or lidocaine? ☐ Yes ☐ No
Allergic to latex? ☐ Yes ☐ No

Do you have a joint replacement? ☐ Yes ☐ No
Do you have a pacemaker or defibrillator? ☐ Yes ☐ No
Do you have a history of a transplant? ☐ Yes ☐ No
Do you take antibiotics before dental procedures? ☐ Yes ☐ No

Do you smoke? ☐ Yes ________ packs per day ☐ No ☐ Former Smoker
Do you drink alcohol? ☐ Yes ________ drinks per week ☐ No

Have you had the influenza (flu) vaccination this year? ☐ Yes ☐ No
For those 65 years of age and older, have you had the pneumonia vaccination? ☐ Yes ☐ No

Are you on the following? (Please circle)

Blood thinners:
Coumadin/warfarin, Heparin, Plavix/clopidogrel, Pradaxa/dabigatran, Xarelto/rivaroxaban
Aspirin
Anti - Inflammatories (NSAIDS, ibuprofen)
Vitamin E
Fish Oil

Are you CURRENTLY having any of the following symptoms (please circle):

Fever Chills Weight loss Loss of Appetite Night Sweats Abdominal Pain Swollen Lymph nodes

Patient Signature: ____ Date: ______________________