CRAIG CREASMAN, M.D. F.A.C. S.

MEDICAL HISTORY FORM

Affix Patient Label HERE

REASON FOR VISIT: ____________________

HISTORY OF PRIOR SURGERIES OR HOSPITALIZATIONS: (month/year) ____________________

____

HISTORY OF TAKING PAIN MEDICATIONS and HOW EFFECTIVE WAS IT? ____________________

____

____

HISTORY OF ANESTHESIA PROBLEMS: ○ Yes ○ No

BLOOD RELATIVES WITH HISTORY OF ANESTHESIA PROBLEMS: ○ Yes ○ No

BLOOD RELATIVE WITH PERTINENT MEDICAL HISTORY: (Cancer, High blood pressure, stroke, heart attack , etc…)

____

____

STATED WEIGHT AND HEIGHT: _________ height _________ weight

List of Medications: (Diet Pills, Herbals, Vitamins, Over the Counter and Prescription Drugs)

- ❑ Med: ____________ Dose: _____ Frequency: _____
- ❑ Med: ____________ Dose: _____ Frequency: _____
- ❑ Med: ____________ Dose: _____ Frequency: _____
- ❑ Med: ____________ Dose: _____ Frequency: _____
- ❑ Med: ____________ Dose: _____ Frequency: _____

Medication Allergies: ○ Yes ○ No

- ❑ Med: ______________ Reaction: ______________
- ❑ Med: ______________ Reaction: ______________
- ❑ Med: ______________ Reaction: ______________

Latex Allergy:	○ Yes ○ No	If Yes, indicate reaction: ____________________
Adhesive Tape Allergy:	○ Yes ○ No	If Yes, indicate reaction: ____________________
Iodine/Shellfish Allergy:	○ Yes ○ No	If Yes, indicate reaction: ____________________
Food Allergies:	○ Yes ○ No	If Yes, indicate reaction: ____________________

HEALTH HISTORY: Do YOU experience any of these symptoms? (Select One)

Seizure disorders?	○ Yes ○ No	If Yes, please explain ____________________
Blackouts/Fainting?	○ Yes ○ No	If Yes, please explain ____________________
Headaches or Migraines?	○ Yes ○ No	If Yes, please explain ____________________
Neck stiffness or pain?	○ Yes ○ No	If Yes, please explain ____________________
Neck injury?	○ Yes ○ No	If Yes, please explain ____________________
Prior stroke?	○ Yes ○ No	If Yes, please explain ____________________
Psychiatric Disorders? (Depression, Anxiety, Bipolar, etc…) ○ Yes ○ No		
If Yes, please explain ____________________		
Alcohol Use?	○ Yes ○ No	If Yes, how much? ____________________
Recreational drug use?	○ Yes ○ No	If Yes, please explain ____________________
Do you smoke?	○ Yes ○ No	If Yes, how much? ________ packs/per day _________ years

Hearing Loss?	○ Yes ○ No	If Yes, please explain ____________________
Vision Loss?	○ Yes ○ No	If Yes, please explain ____________________
Corrective lenses?	○ Yes ○ No	If Yes, designate glasses or contact lenses ____________________
Dry eyes?	○ Yes ○ No	If Yes, please explain ____________________
Eye pain?	○ Yes ○ No	If Yes, please explain ____________________

Nose bleeds?	○ Yes ○ No	If Yes, how often? ____________________
Runny nose?	○ Yes ○ No	If Yes, how often? ____________________
Nasal congestion?	○ Yes ○ No	If Yes, how often? ____________________
Seasonal allergies?	○ Yes ○ No	If Yes, please explain ____________________
Broken nose?	○ Yes ○ No	If Yes, please explain ____________________
Deviated Septum?	○ Yes ○ No	If Yes, please explain ____________________

Dentures/Partial plates/Crowns?	○ Yes ○ No	If Yes, please explain ____________________
History of cold sores/fever blisters?	○ Yes ○ No	If Yes, please explain ____________________
Dental problems?	○ Yes ○ No	If Yes, please explain ____________________
Problems chewing or swallowing?	○ Yes ○ No	If Yes, please explain ____________________
Change in voice or hoarseness?	○ Yes ○ No	If Yes, please explain ____________________

Bleeding disorder? ○ Yes ○ No If Yes, please explain ______
Heart attack? ○ Yes ○ No If Yes, please explain ______
Chest Pain/Angina? ○ Yes ○ No If Yes, please explain ______
Heart palpitations? ○ Yes ○ No If Yes, how often? ______
Heart murmurs? ○ Yes ○ No If Yes, please explain ______
Mitral Valve Prolapse? ○ Yes ○ No High cholesterol? ○ Yes ○ No
High blood pressure? ○ Yes ○ No Prior blood transfusions? ○ Yes ○ No

Shortness of breath with exertion? ○ Yes ○ No If Yes, please explain ______
Asthma/Wheezing? ○ Yes ○ No If Yes, please explain ______
Pneumonia? ○ Yes ○ No If Yes, when? ______
Chronic cough/phlegm? ○ Yes ○ No If Yes, please explain ______
History of Tuberculosis? ○ Yes ○ No If Yes, please explain ______
Lung Disease? ○ Yes ○ No If Yes, please explain ______

History of breast cancer? ○ Yes ○ No If Yes, please explain ______
Family history of breast cancer? ○ Yes ○ No If Yes, please explain ______
Breast pain? ○ Yes ○ No If Yes, please explain ______
Fibrous breast tissue/Lumps/Cysts? ○ Yes ○ No If Yes, please explain ______
Last mammogram? ______ month ______ year ______ facility
Breast feeding history? ○ Yes ○ No ○ n/a Number of children breast fed ______ Problems? ○ Yes ○ No

Diabetes? ○ Yes ○ No If Yes, please explain ______
Gastric Reflux (GERD)? ○ Yes ○ No If Yes, please explain ______
Ulcerative Colitis? ○ Yes ○ No If Yes, please explain ______
Peptic ulcer? ○ Yes ○ No If Yes, please explain ______
Kidney disease? ○ Yes ○ No If Yes, please explain ______
Liver disease? ○ Yes ○ No If Yes, please explain ______
Abdominal pain? ○ Yes ○ No If Yes, please explain ______
Chronic constipation and/or diarrhea? ○ Yes ○ No If Yes, please explain ______
Weight loss? ○ Yes ○ No If Yes, please explain ______
Weight gain? ○ Yes ○ No If Yes, please explain ______

Number of pregnancies? ___ Number of children? ___ Frequent yeast infections? ○ Yes ○ No
Heavy menstrual flow? ○ Yes ○ No Frequent urinary tract infections? ○ Yes ○ No

Immune system disorder? ○ Yes ○ No If Yes, please explain ______
History of Hepatitis? ○ Yes ○ No If Yes, please explain if A, B or C? ______
Venereal disease? ○ Yes ○ No If Yes, please explain ______
HIV? ○ Yes ○ No
For adolescents (less than 18 years of age): Are immunizations up to date? ○ Yes ○ No

Numbness/tingling/tremors in limbs? ○ Yes ○ No Varicose veins? ○ Yes ○ No
Limited range of movement/weakness? ○ Yes ○ No Blood clot in legs? ○ Yes ○ No
Back pain? ○ Yes ○ No Restless leg syndrome? ○ Yes ○ No
Swelling of ankles? ○ Yes ○ No Pain in legs when walking? ○ Yes ○ No

History of Retin A use? ○ Yes ○ No Port Wine Stain/Skin Pigmentation? ○ Yes ○ No
Herpes Simplex? ○ Yes ○ No Melanoma/Psoriasis/Vitiligo? ○ Yes ○ No
Chronic Acne? ○ Yes ○ No Shingles? ○ Yes ○ No
Accutane within the past year? ○ Yes ○ No

When you sunbathe, how does your skin respond?

☐ Always burn, never tan ☐ Sometimes burn, tan about average ☐ Rarely burn, tan easily
☐ Usually burn, tan with difficulty ☐ Almost never burn, tan easily ☐ Never burn, always tan

______
Patient Signature

______
Date

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