

Date: _____

Dr. Carolyn Hale, M.D.

Joel James, P.A.-C

Name: _____ Date of Birth: _____ Referred by: _____

Are you allergic to any medications?

1. _____ 2. _____ 3. _____

MEDICAL HISTORY: Do you or have you had any of the following?

Cardiovascular	Present	Past
High Blood Pressure		
Chest Pain		
Heart attack		
Heart murmur		
Irregular pulse or palpitations		
Varicose veins		
Blood Clots		
Pacemaker		
Blood thinners		
Edema or swollen ankles		
High Cholesterol or triglycerides		
Deep vein thrombosis		

Gastrointestinal	Present	Past
Ulcer		
Liver disease or hepatitis		
Crohns or Inflammatory bowel		
Persistent nausea or vomiting		
Acid reflux (GERD)		
Diarrhea		
Abdominal pain		

Respiratory	Present	Past
Cough		
Wheezing		
History of Tuberculosis		
Difficulty breathing		
Asthma		

Endocrine	Present	Past
Hair Loss		
Excess hair or Hirsutism		
Diabetes		
Thyroid disease		

Allergic-Immunologic	Present	Past
Hay fever		
Hives		
Chemotherapy		
Lupus-scleroderma		
Immunosuppressed		
Organ transplant		
Rheumatoid Arthritis		
Chronic Fatigue		
Anemia		
Bleeding tendencies		

Constitutional	Present	Past
Fever		
Chills		
Dizziness or fainting		
Fatigue		
Weight Change		

Neurological	Present	Past
Headache		
Seizures		
Stroke		
Numbness		
Paralysis		

Eyes	Present	Past
Acuity Change		
Irritation		
Blurred Vision		
Decreased night vision		
Glaucoma		

Skin	Present	Past
Rash		
Thinning hair		
Photosensitivity		
Psoriasis		
Eczema		
Vitiligo		
Acne		
Fungal infection		
Large number of moles		
Changing moles		
Mole removal		
Skin ulcers		
Herpes-cold sores		
Shingles		
Other skin conditions		

Psychiatric	Present	Past
Nervousness		
Depression		
Stressful event		
Sucidial thoughts		
Mental illness		

Musculoskeletal	Present	Past
Arthritis		
Artificial joint		
Cramps		
Pain		
Weakness		

Urology-GYN	Present	Past
Kidney disease-Dialysis		
Painful urination		
History of STD		
Menstrual cycle		
Regular menstrual cycle		
Pregnant		
Planning pregnancy		

PLEASE SEE BACK

Family History	Family member	Self
Cancer		
Skin cancer		
Diabetes		
Psoriasis		
Eczema		

Please list prior surgeries	Date
1	
2	
3	
4	
5	
6	

Habits	Yes		Yes		Yes
Alcohol		Protective sun wear		Skin self examination	
Smoking		Sunglasses-Hat		Regular use of sunscreen	
Illicit drugs		Tanning beds		SPF level	

Current Medications

Medication	Dosage	Times per day
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		