





**PATIENT HISTORY SHEET**

Name: Soc. Sec. #: Date:

Date of Birth: Sex: Age:

Occupation:

Referred by Dr.: Family Physician, Dr.:

State briefly the problem(s) for which you were referred here:

Are you allergic to any medicine?

List medicines you take - (also bring them with you):

**PAST HISTORY:**

Have you ever had skin cancer or melanoma?

Has any immediate family member had skin cancer or melanoma?

Have you been treated for skin problems in the past?

Unusual childhood illness?

Have you ever had any of the following?

- |  |                                |
|--|--------------------------------|
| Weight change over the past year         | Rheumatic Fever                |
| Goiter or Thyroid Trouble                | Pneumonia                      |
| Ever had X-Ray treatment to head or neck | Malaria                        |
| Kidney or Bladder Infections             | Cancer                         |
| Kidney Stones                            | Epilepsy                       |
| Hepatitis or Yellow Jaundice             | Stroke                         |
| Stomach or Duodenal Ulcer, Colon Trouble | Diabetes (sugar)               |
| High Blood Pressure                      | Asthma                         |
| Heart Trouble                            | Pleurisy                       |
| Heart Murmur                             | Last eye exam - Glaucoma check |
| Tuberculosis (T.B.)                      | Last Pap. Smear                |
| Last EKG (Electrocardiogram)             | Menstrual Problems             |
| Last Chest X-Ray                         |                                |

List operations, serious injuries, fractures, hospitalizations, and dates of each:

**PERSONAL HISTORY:**

Married?	Age of spouse?	Health?
Children?	Ages?	Health?
Hobbies?		
Do you smoke?	What?	How much?
Do you drink alcoholic beverages?	What?	How much?
Work - How many hours a week?	What is your job?	
Are you on disability?	Are you on medicare?	
Are you on medicaid?	Are you on workman's compensation?	

**FAMILY HISTORY:**

	Age	Living	Dead	Age at Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Have any members of your immediate family (blood relative) had:

- Diabetes
- Tuberculosis
- Heart Trouble
- Cancer
- High Blood Pressure
- Stroke
- Goiter
- Rheumatoid Arthritis
- Blood Disease