



# ENHANCEMENT MEDICAL HISTORY FORM

Name \_\_\_\_\_

Age \_\_\_\_\_ Date \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

List all **medications** you are currently taking include non-prescription meds and birth control:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

List any **allergies to meds** and reaction:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Are you pregnant or nursing? Yes No

List all of your lifetime surgeries and major injuries:

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**Family History:** Please check all diseases that have been present in your family and note who had the disease.

(Patient, Mother, Father, Brother, Sister, Grandparent, Other)

- |                            |                              |                        |
|----------------------------|------------------------------|------------------------|
| _____ Allergies / Hayfever | _____ Skin Cancer / Melanoma | _____ Vascular Disease |
| _____ Asthma               | _____ Hepatitis A, B, C      | _____ HIV / AIDS       |
| _____ Psoriasis            | _____ Cancer                 | _____ Arthritis        |
| _____ Eczema               | _____ Stroke                 | _____ Diabetes         |

### Social History:

Current/past occupation \_\_\_\_\_

Hobbies \_\_\_\_\_

Do you smoke? **Yes No** Packs per day \_\_\_\_\_ Years \_\_\_\_\_ History of smoking? **Yes No**

Do you drink alcohol? **Yes No** Amount per week \_\_\_\_\_

Are you at high risk for AIDS? **Yes No**

Have you been HIV tested? **Yes No**

HIV Test Results: negative positive

History of drug abuse? **Yes No**

Hepatitis Immunized? **Yes No** If yes, Date \_\_\_\_\_

**Please turn over and complete both sides →**

# MEDICAL HISTORY FORM

Name \_\_\_\_\_

List all current and past **health problems**

1. \_\_\_\_\_

4. \_\_\_\_\_

2. \_\_\_\_\_

5. \_\_\_\_\_

3. \_\_\_\_\_

6. \_\_\_\_\_

## Review of Systems:

**General Health** - \_\_\_\_\_

**Please circle symptoms you are now having or chronically recur:**

**Skin type** - tans easily, some burn/some tan, burns easily

**Skin** - Itching, Rash, Hair Loss, Nail Problems, Growths, Skin Cancer, Psoriasis, Eczema, Thick Scars, Moles changing or growing, Athlete's Foot, Jock Itch, Ringworm, Sores that won't heal, Dark spots after pregnancy or injury, other \_\_\_\_\_

**Lungs** - Asthma, Pulmonary Embolism, Allergies, other \_\_\_\_\_

**Heart** - Leg swelling, High Blood Pressure, Heart Attack, other \_\_\_\_\_

**Neurological** - Stroke, TIA's (mini-stroke), other \_\_\_\_\_

**Endocrine** - Thyroid Disease, Diabetes, Excess Hair Growth, Polycystic Ovarian Syndrome, other \_\_\_\_\_

**Psychiatric** - Depression, Obsessive-Compulsive, Nervousness, Anxiety, Stress, other \_\_\_\_\_

**Blood Disorders** - Anemia, Leukemia, Bleeding/Clotting disorder, Blood Thinners, other \_\_\_\_\_

**Immunologic** - Lupus, Scleroderma, Vitiligo, Polymyositis, other \_\_\_\_\_

## PARENTAL CONSENT FOR CHILD UNDER 18 YEARS OF AGE

I am present with my child \_\_\_\_\_ today and I give my consent to \_\_\_\_\_ (Dr. Cooperrider / Dr. Strother / Denise McNatt, PA-C / Angela Fulton, PA-C) to see and treat my child as indicated.

Signature of Parent or Guardian \_\_\_\_\_

If the patient is under 18 and his/her condition requires follow-up, I give permission for continued care in my absence for this condition. No invasive procedures will be performed without direct notification to the parent.