MARK R. KAISER, M.D., P.A.
PATIENT MEDICAL HISTORY

Patient Name: _____ **Date:** _____

Do you have now, or have you ever had diseases or a condition of:

	Yes	No		Yes	No
Lungs:					
Bronchitis	❑	❑	Diabetes	❑	❑
Emphysema	❑	❑	Thyroid	❑	❑
Asthma	❑	❑	Kidney	❑	❑
Chronic Cough	❑	❑	Bladder	❑	❑
Hay Fever	❑	❑	Stomach	❑	❑
			Bowel	❑	❑
Heart:			Liver	❑	❑
High Blood Pressure	❑	❑	Arthritis	❑	❑
Chest Pain	❑	❑	Fainting	❑	❑
Heart Attack	❑	❑	Glaucoma	❑	❑
Heart Murmur	❑	❑	Phlebitis	❑	❑
Heart Beat (irreg. or fast)	❑	❑	Epilepsy or Seizures	❑	❑
Pacemaker	❑	❑	AIDS Exposure	❑	❑

Skin

When exposed to the sun do you ❑ Tan only ❑ Tan and Burn ❑ Burn only

Have you ever had skin cancer? ❑ Yes ❑ No

Have you ever been diagnosed with melanoma? ❑ Yes ❑ No

Has anyone in your family had skin cancer? ❑ Yes ❑ No

Do you have a history of any specific skin disease? ❑ Yes ❑ No

If yes, list: _____

List any other disease or condition we should know about: _____

List surgical procedures you have had in the past 5 years: _____

Please answer the following questions:

A. Do you consume alcohol? ❑ Yes ❑ No

B. Do you bleed easily? ❑ Yes ❑ No

C. Do you smoke? ❑ Yes ❑ No

D. Women, are you pregnant or breast feeding? ❑ Yes ❑ No

E. Do you have artificial joints? ❑ Yes ❑ No

Medications

A. Do you take antibiotics prior to dental work? ❑ Yes ❑ No

B. Are you allergic to any medications? ❑ Yes ❑ None as of this date.

If yes, list _____

C. List all medications you are currently taking:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

FOR OFFICE USE ONLY: PC

Completed by: ❑ Patient ❑ Medical Assistant _____ **Account #** _____ RX

Updated: _____ _____ _____ _____ _____ _____ PreMed