

**ELIZABETH A. LIOTTA, MD, LLC**  
**Patient Medical History**  
(Please Print Clearly)

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Reason for visit \_\_\_\_\_

**General Health** (Please Circle Appropriate Response)

- YES NO Are you in good general health?
- YES NO (Women) Are you pregnant?
- YES NO Are you now taking any drugs or medication?  
Which ones? \_\_\_\_\_
- YES NO Are you allergic to any medications?  
Which ones? \_\_\_\_\_
- YES NO Would you object to our office contacting your family doctor in regard to any medical problem that may arise?
- YES NO Have you had any surgical procedures?  
Please list: \_\_\_\_\_
- YES NO Have you ever had any adverse reaction to either local or general anesthesia?  
Please describe \_\_\_\_\_
- YES NO Do you take aspirin products or anti-inflammatory medicines or headache medicines?

**Do you have now or have you ever had diseases or conditions of: (Please check YES or NO)**

	YES	NO		YES	NO
<b>Lungs</b>			<b>Other Systemic</b>		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal		
<b>Cardiovascular</b>			Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, vomiting, diarrhea when taking medicine	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection when taking Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>			

**Skin** (Please Circle Appropriate Response)

- YES NO Have you ever had skin cancer? If Yes, \_\_\_\_\_
- YES NO Do you have a history of any specific skin disease? If Yes, \_\_\_\_\_
- YES NO Do you develop bad scars after surgery or problems with healing?  
Explain \_\_\_\_\_

**Family History** (Please Circle Appropriate Response)

- YES NO Has anyone in your family had skin cancer or skin disease? If Yes, \_\_\_\_\_

**Social History** (Please Circle Appropriate Response)

- YES NO Do you drink alcohol? If yes, \_\_\_\_\_ drinks per week
- YES NO Do you smoke? If yes, how much per day \_\_\_\_\_ per week \_\_\_\_\_

<b>Patient Signature</b>	<b>Date</b>
<b>Reviewed By</b>	<b>Date</b>