

Rondi Kathleen Walker, M.D.

PATIENT MEDICAL HISTORY

This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when/if you have authorized us to do so.

Name: _____ Date: _____

Age: _____ Birthdate: _____

Reason for visit: _____

ALLERGIES:

Name of Medication: _____

Please describe symptoms and treatment:

MEDICAL HISTORY:

List hospitalizations (Use back if necessary).

Have you taken penicillin without problems?
Are you allergic to shellfish or Iodine?
Have you ever smoked? How many per day?
Date of last cigarette?
Has any blood relative ever had the following?
If so, relationship to you,
Cancer _____
Tuberculosis _____
Diabetes _____
Heart Trouble _____
Bleeding disorder _____
High Blood Pressure _____
Stroke: _____
Epilepsy _____

List all medications:
Drugs: Dose: Reason:

Do you require Antibiotic prophylaxis prior to dental work? _____
Have you ever taken Acutane? _____
Do you take Aspirin or Ibuprofen? (Advil, Motrin, Aleve)? Dosage: _____

SURGICAL HISTORY:

List type and date of your surgeries:

PERSONAL HISTORY:

Weight _____
Height _____
Bra size _____

GYNECOLOGICAL HISTORY:

Number of pregnancies: _____
Type of delivery: _____

SKIN CARE HISTORY:

What is your current skin care program? _____
(including glycolic acid)? _____
Is your skin dry, oily or combination?
Sensitive to cosmetics or pharmaceutical products?

ILLNESSES: (please circle)

Blood transfusion
Pneumonia
Rheumatic Fever
Heart Disease
Arthritis
Bone or Joint Disease
Diabetes
Polio
Colitis
Gonorrhea, Syphilis or Sexually Transmitted Disease

Gallbladder Disease
Anemia
Jaundice
Epilepsy
Migraine Headache
Tuberculosis
Cancer
High/Low Blood Pressure
Kidney Stones
Food/Chemical/Drug Poisoning

Hay fever or Asthma
Hives or Eczema
Frequent Infections
AIDS
Herpes Simplex (Cold Sores)
Neuritis or Neuralgia
Bursitis, Sciatica or Lumbago
Meningitis
Nervous Breakdown