ART QUINTANILLA, MD
BOARD CERTIFIED PHYSICIAN

DESERT MEDICAL REJUVENATION

MEDICAL HISTORY FORM

REVIEW OF SYSTEMS

Do you have now, or have you ever had any of the listed diseases or conditions?:

DERMATOLOGY
( ) oily skin
( ) dry skin
( ) red or brown spots
( ) fine lines/wrinkles
( ) sun damage

GENERAL
( ) currently pregnant
( ) currently breastfeeding
( ) diabetes
( ) reaction to antibiotics
( ) reaction to bandages
( ) anticoagulant daily

ENDOCRINE
( ) excessive sweating
( ) heat/cold intolerance

MUSCULOSKELETAL
( ) arthritis/joint deformity
( ) artificial joints

GASTROENTEROLOGY
( ) nausea
( ) vomiting
( ) gastro-intestinal problems

PHSYCHOLOGY
( ) depressions
( ) suicidal thoughts
( ) mental or physical abuse
( ) mood swings
( ) obsessive-compulsive

BLOOD/LYMPH
( ) swollen glands
( ) fatigue
( ) varicose veins
( ) easy bruising
( ) bleed easily
( ) blood clots
( ) thyroid problems

CARDIOLOGY
( ) chest pain
( ) palpitations
( ) leg swelling
( ) heart attack
( ) high blood pressure
( ) pacemaker

NEUROLOGY
( ) headaches
( ) tingling/numbness
( ) seizures/dizziness

RESPIRATORY
( ) asthma
( ) chest tightness
( ) cough/wheezing
( ) bronchitis
( ) emphysema

ALLERGIES

Are you allergic to any medications? ( ) YES ( ) NO
If yes, please list:_____

MEDICATIONS/PRODUCTS

Pharmacy of Choice:_____ Pharmacy Phone #:_____ Cross Streets:_____
Please list all medications you are currently taking (including prescriptions, over-the-counter meds, and vitamins):
Prescriptions: _____
Over-the-counter:_____

PAST MEDICAL HISTORY

Do you drink alcohol? ( ) YES ( ) NO If yes, how many per day?_____
Do you smoke? ( ) YES ( ) NO If yes, how many per day?_____
Have you ever been exposed to HIV (AIDS) or Hepatitis? ( ) YES ( ) NO
Have you ever had skin cancer? ( ) YES ( ) NO
If yes, please describe:_____
Do you have a history of Melanoma? ( ) YES ( ) NO
If yes, please describe:_____
Has anyone in your family had a history of skin cancer? ( ) YES ( ) NO
If yes, please describe:_____
Do you have a history of any specific skin diseases/reactions? ( ) YES ( ) NO
If yes, please describe:_____
List any other diseases or conditions:_____
List any surgical procedures you have had in the past year:_____
Height:_____ Weight: _____

MEDICAL HISTORY FORM (CONTINUED)

PAST HISTORY

Asthma, bronchitis, bronchiolitis, or pneumonia	( ) YES ( ) NO ( ) DK	Explain_____
Any heart problem or heart murmur	( ) YES ( ) NO ( ) DK	Explain_____
Anemia or bleeding problem	( ) YES ( ) NO ( ) DK	Explain_____
Blood transfusion	( ) YES ( ) NO ( ) DK	Explain_____
HIV	( ) YES ( ) NO ( ) DK	Explain_____
Organ transplant	( ) YES ( ) NO ( ) DK	Explain_____
Malignancy/bone marrow transplant	( ) YES ( ) NO ( ) DK	Explain_____
Chemotherapy	( ) YES ( ) NO ( ) DK	Explain_____
Frequent abdominal pain	( ) YES ( ) NO ( ) DK	Explain_____
Constipation requiring doctor visits	( ) YES ( ) NO ( ) DK	Explain_____
Recurrent urinary tract infections and problems	( ) YES ( ) NO ( ) DK	Explain_____
Congenital cataracts/retinoblastoma	( ) YES ( ) NO ( ) DK	Explain_____
Metabolic/Genetic disorders	( ) YES ( ) NO ( ) DK	Explain_____
Cancer	( ) YES ( ) NO ( ) DK	Explain_____
Kidney disease or urologic malformations	( ) YES ( ) NO ( ) DK	Explain_____
Sleep problems; snoring	( ) YES ( ) NO ( ) DK	Explain_____
Chronic or recurrent skin problems (e.g. acne, eczema)	( ) YES ( ) NO ( ) DK	Explain_____
Frequent headaches	( ) YES ( ) NO ( ) DK	Explain_____
Convulsions or other neurologic problems	( ) YES ( ) NO ( ) DK	Explain_____
Obesity	( ) YES ( ) NO ( ) DK	Explain_____
Diabetes	( ) YES ( ) NO ( ) DK	Explain_____
Thyroid or other endocrine problems	( ) YES ( ) NO ( ) DK	Explain_____
High blood pressure	( ) YES ( ) NO ( ) DK	Explain_____
History of serious injuries/fractures/concussions	( ) YES ( ) NO ( ) DK	Explain_____
Use of alcohol or drugs	( ) YES ( ) NO ( ) DK	Explain_____
Tobacco use	( ) YES ( ) NO ( ) DK	Explain_____
Sexually transmitted infections	( ) YES ( ) NO ( ) DK	Explain_____
Pregnancy	( ) YES ( ) NO ( ) DK	Explain_____

BIOLOGICAL FAMILY HISTORY DK= DON'T KNOW

Have any family members had the following?	( ) YES ( ) NO ( ) DK	Who_____ Comments_____
Tuberculosis	( ) YES ( ) NO ( ) DK	Who_____ Comments_____
Heart disease (before 55 years old)	( ) YES ( ) NO ( ) DK	Who_____ Comments_____
High cholesterol/takes cholesterol medication	( ) YES ( ) NO ( ) DK	Who_____ Comments_____
Anemia	( ) YES ( ) NO ( ) DK	Who_____ Comments_____
Bleeding disorder	( ) YES ( ) NO ( ) DK	Who_____ Comments_____
Cancer (before 55 years old)	( ) YES ( ) NO ( ) DK	Who_____ Comments_____
Liver disease	( ) YES ( ) NO ( ) DK	Who_____ Comments_____
Kidney disease	( ) YES ( ) NO ( ) DK	Who_____ Comments_____
Diabetes (before 55 years old)	( ) YES ( ) NO ( ) DK	Who_____ Comments_____
Obesity	( ) YES ( ) NO ( ) DK	Who_____ Comments_____
Epilepsy or convulsions	( ) YES ( ) NO ( ) DK	Who_____ Comments_____
Alcohol abuse	( ) YES ( ) NO ( ) DK	Who_____ Comments_____
Drug abuse	( ) YES ( ) NO ( ) DK	Who_____ Comments_____
Mental illness/depression	( ) YES ( ) NO ( ) DK	Who_____ Comments_____
Developmental disability	( ) YES ( ) NO ( ) DK	Who_____ Comments_____
Immune problems, HIV, or AIDS	( ) YES ( ) NO ( ) DK	Who_____ Comments_____
Tobacco use	( ) YES ( ) NO ( ) DK	Who_____ Comments_____

Additional family history _____

_____

I attest that the information I have provided above is correct, complete and current, realizing that the medical care provided to me may be based on this information.

PATIENT SIGNATURE_____**DATE**_____