

*Marlene J. Mash, MD & Associates  
Benjamin Lam, D.O., F.A.C.O.S.  
545 West Germantown Pike – Suite 100  
Plymouth Meeting, PA 19462  
484-351-8268*

**Medical History**

Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Allergies:  yes  no If yes, please list all: \_\_\_\_\_

Medications:

Past Surgeries:

_____	_____	Year: _____
_____	_____	Year: _____
_____	_____	Year: _____
_____	_____	Year: _____
_____	_____	Year: _____

Do you take aspirin or blood thinners:  yes  no If yes, how often? \_\_\_\_\_

Please check YES or NO to the following:

Angina  yes  no

Thyroid  yes  no

Vascular Disease  yes  no

Hypertension  yes  no

Arthritis  yes  no

Hepatitis  yes  no If yes, list type: \_\_\_\_\_

Asthma or Lung Disease  yes  no

TB or Aids  yes  no

Breast Cancer  yes  no

History of Family Skin Cancer  yes  no

History of Fever Blisters  yes  no

Blackouts  yes  no

Anesthesia Problems  yes  no

Alcohol Abuse  yes  no

Kidney Disease  yes  no

Diabetes  yes  no

Eye Problems  yes  no

Received Blood Transfusion  yes  no

Heart Attack or Stroke  yes  no

Liver Problems  yes  no

GI Problems or Ulcers  yes  no

Seizures  yes  no

History of Skin Cancer  yes  no

History of Psoriasis  yes  no

Bleeding Disorders  yes  no

Drug Abuse  yes  no

Tobacco Use  yes  no

Other \_\_\_\_\_

Patient Signature \_\_\_\_\_ Interviewer \_\_\_\_\_