MEDICAL HISTORY

PATIENT NAME:_____ **DATE:**_____

REASON FOR YOUR VISIT: _____

PAST MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Anxiety	Transplantation	End Stage Renal Disease	Hyperthyroidism	Prostate Cancer
Arthritis	Breast Cancer	GERD	Hypothyroidism	Radiation Treatment
Artificial joints	Colon Cancer	Hearing Loss	Leukemia	Seizures
Asthma	COPD	Hepatitis	Lung Cancer	Systemic Lupus
Atrial fibrillation	Coronary Artery Disease	High Blood Pressure	Lymphoma	Stroke
Enlarged Prostate	Depression	HIV/AIDS	Pacemaker	Valve Replacement
Bone Marrow	Diabetes	High Cholesterol		None

Other Cancers or Diseases not listed: _____

PAST SURGICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Appendix Removed	Mechanical Valve Replacement	Prostate Removed: Prostate CA
Bladder Removed	Biological Valve Replacement	Prostate Biopsy
Mastectomy (Right,Left,Bilateral)	Heart Transplant	Prostate Resection
Lumpectomy (Right,Left,Bilateral)	Joint Replacement	Skin Biopsy
Breast Biopsy (Right,Left,Bilateral)	Knee (Right,Left,Bilateral)	Basal Cell Cancer Surgery
Breast Reduction	Hip (Right,Left,Bilateral)	Squamous Cell Carcimoma
Breast Implants	Kidney Biopsy	Melanoma Surgery
Colectomy: Colon Cancer Resection	Kidney Removed (Right,Left)	Spleen Removed
Colectomy: Diverticulitis	Kidney Stone Removal	Testicles Removed
Colectomy: IBD	Kidney Transplant	(Right,Left,Bilateral)
Gallbladder Removed	Ovaries Removed: Endometriosis	Hysterectomy: Fibroids
Coronary Artery Bypass	Ovaries Removed: Cyst	Hysterectomy: Uterine CA
PTCA	Ovaries Removed: Ovarian Cancer	None

Other Surgical Procedures not listed: _____

SKIN DISEASE HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Acne	Eczema	Psoriasis
Actinic Keratoses	Flaking or Itchy Scalp	Squamous Cell Skin
Asthma	Hay Fever/Allergies	Cancer
Basal Cell Skin Cancer	Melanoma	None
Blistering Sunburns	Poison Ivy	
Dry Skin	Precancerous Moles	

Other:_____

Do you wear sunscreen? Yes No If yes, what SPF? _____ Do you tan in a tanning salon: Yes No

Do you have a family history of Melanoma? Yes No If yes, which relative(s)? _____

ALLERGIES: (PLEASE LIST ALL ALLERGIES)

_____

MEDICATIONS: (PLEASE LIST ALL CURRENT MEDICATIONS)

Medication name	Dosage	Frequency	Route (oral, topical,etc.)

SOCIAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Do you smoke? Yes No If yes how much?_____ **IF NO, have you smoked in the past?** Yes No

Do you drink alcohol? Yes No If yes, how many drinks per day? _____

Do you use drugs? Yes No If yes, what type? _____

What is your occupation?_____

What are your hobbies?_____

Continue to back of page...

MEDICAL HISTORY (PAGE 2)

REVIEW OF SYSTEMS: Are you currently experiencing any of the following?
(PLEASE CHECK YES OR NO)

	Yes	No
Allergy to Topical Antibiotic Ointments		
Yeast Infection With Antibiotics		
GI Upset With Antibiotics		
Problems With Bleeding		
Problems With Scarring (hypertrophic or keloid)		
Immunosuppression		
Changing Mole		
Rash		
Abdominal Pain		
Anxiety		
Bloody Stool		
Bloody Urine		
Blurry Vision		
Chest Pain		
Cough		
Depression		
Fever or Chills		
Headaches		
Hay Fever		
Joint Aches		
Muscle Weakness		
Neck Stiffness		
Night Sweats		
Seizures		
Shortness of Breath		
Sore Throat		
Thyroid Problems		
Unintentional Weight Loss		
Wheezing		

CAUTIONS:

Do you have a pacemaker?	Yes	No	
Do you have a defibrillator?	Yes	No	
Have you had an artificial joint replacement within past 2 years?	Yes	No	If yes, what body locations? _____
Do you have an artificial heart valve?	Yes	No	
Do you need premedication prior to procedures?	Yes	No	
Do you have an allergy to adhesives?	Yes	No	
Are you on blood thinner medication?	Yes	No	
Are you pregnant or planning a pregnancy or nursing?	Yes	No	
Are you allergic to lidocaine?	Yes	No	
Do you experience rapid heart beat with epinephrine?	Yes	No	
Do you have Polycystic Ovarian Disease?	Yes	No	
Do you have Hepatitis?	Yes	No	
Do you have HIV/AIDS?	Yes	No	

Other Symptoms: _____

Other Concerns: _____

Pharmacy Name: _____ **Pharmacy Telephone Number:** _____

Pharmacy Address: _____

PATIENT OR GUARDIAN SIGNATURE: _____ **DATE:** _____

PHYSICIAN SIGNATURE: _____ **DATE:** _____