PLEASE PRINT

Name _____ Date _____

Date of Birth _____

MEDICAL INFORMATION
PLEASE COMPLETE ALL 3 PAGES

PAST MEDICAL HISTORY: **(Please circle all that apply)**

Anxiety
Arthritis
Asthma
Atrial Fibrillation
BPH
Breast Cancer
Cerebrovascular Accident (Stroke)
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
Epilepsy
GERD
Hearing Loss
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Liver Disease
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment

Other _____ None

PAST SURGICAL HISTORY: **(Please circle all that apply)**

Appendectomy
Bladder Surgery
Breast Surgery
- Mastectomy
- Lumpectomy
- Reduction
- Implants

Colon Surgery
- Cancer Resection
- Diverticulitis
- Inflammatory Bowel Disease

Gall Bladder Removal
Heart Surgery
- Bypass
- Angioplasty
- Valve Replacement
- Transplant

Skin Surgery
- Biopsy
- Basal Cell Carcinoma
- Squamous Cell Carcinoma
- Malignant Melanoma

Joint Replacement
- Hip, Right
- Hip, Left
- Knee, Right
- Knee, Left

Kidney Surgery
- Biopsy
- Nephrectomy
- Stone Removal
- Transplant

Ovarian Surgery
- Endometriosis
- Ovarian Cyst
- Ovarian Cancer

Prostate Surgery
- Cancer
- Biopsy
- TURP

Spleen Surgery
Testicular Surgery
Uterine Surgery/Hysterectomy
- Fibroids
- Cancer

Other _____ None

CONTINUE →

SKIN DISEASE HISTORY:

Acne
Actinic Keratosis
Asthma
Basal Cell Carcinoma
Blistering Sunburns
Dry Skin
Eczema
Other _____

Flaking or Itchy Skin
Hay Fever/Allergies
Malignant Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Carcinoma
None

DO YOU WEAR SUNSCREEN? YES NO
If YES, what SPF? _____
DO YOU TAN IN A TANNING SALON? YES NO

FAMILY HISTORY

Do you have a family history of Malignant Melanoma? YES NO
If yes, which relative(s) _____

MEDICATIONS: (Please list)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

MEDICATION ALLERGIES: (Please List All Medication Allergies Below)

_____
_____

PHARMACY NAME/CITY: _____

PHARMACY PHONE NUMBER: _____

SOCIAL HISTORY:

Alcohol Use? YES NO
Drug Use? YES NO
Smoking Status:
- Current Smoker
- Former Smoker
- Never Smoked

How often do you Exercise?
- Daily
- Weekly
- Monthly
- Never

Caffeine use?
Daily
Weekly
Monthly
None

Pregnancy Status?
Currently pregnant
Planning to become pregnant
Not pregnant

CONTINUE →

OCCUPATION: _____

REVIEW OF SYSTEMS: (**Please circle all that apply**)

Anxiety
Abdominal Pain
Bloody Stool
Bloody Urine
Blurry Vision
Chest Pain
Cough
Decrease in night vision
Depression
Fever or Chills
Headaches
Immunosuppression
None
Joint Aches
Muscle Weakness
Neck Stiffness
Night Sweats
Problems with bleeding
Problems with healing
Problems with scarring (hypertrophic or keloid)
Rash
Shortness of Breath
Sore Throat
Thyroid Problems
Unintentional Weight Loss
Wheezing

ALERTS: (**Please circle all that apply**)

Allergy to adhesive
Allergy to lidocaine
Allergy to topical antibiotic ointments
Artificial joints within past 2 years
Defibrillator
Rapid heartbeat with epinephrine
Exposure to other high risk disease
None
MRSA
Pacemaker
Artificial heart valve
Blood thinners
Premedication prior to procedures
Personal Exposure to Ebola
Travel to Africa or China

PREFERRED LANGUAGE: _____

RACE/ETHNIC GROUP:

( ) White
( ) Asian
( ) Native Hawaiian or other Pacific Islander
( ) American Indian or Alaska Native
( ) Black or African American
( ) Other Race _____

ETHNICITY:

( ) Hispanic or Latino
( ) Unknown
( ) Not Hispanic or Latino