

*****MEDICAL HISTORY*****

Name: _____ Date of Birth: _____ Today's Date: _____

Reason for Visit: _____

Past Medical History: (please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hepatitis, Type _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hypertension (High blood pressure) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Hypercholesterolemia (High cholesterol) |
| <input type="checkbox"/> Cancer, Type _____ | <input type="checkbox"/> Hyperthyroidism (Over active thyroid) |
| <input type="checkbox"/> Crohn's disease/Ulcerative Colitis | <input type="checkbox"/> Hypothyroidism (Under active thyroid) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Pacemaker/Defibrillator |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> End Stage Renal Disease (kidney disease) | <input type="checkbox"/> Valve Replacement |
| <input type="checkbox"/> Fainting | |

Other Medical History

Past Surgical History: (please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Mechanical Valve Replacement | <input type="checkbox"/> Organ Transplant, Type _____ |
| <input type="checkbox"/> Biological Valve Replacement | <input type="checkbox"/> Joint Replacement, Type _____ |

Other Past Surgical History

Skin Disease History: (please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Hay Fever/Allergies |
| <input type="checkbox"/> Actinic Keratoses | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Mohs Surgery |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> Flaking or Itchy Scalp | |

Other Skin Disease History

Medical Questions Continued: (please circle)

- Do you wear Sunscreen? Yes No If yes, what SPF? _____
- Do you tan in a tanning salon? Yes No
- Family history of Melanoma: Yes No If yes, which relative(s)? _____

Social History: (please circle)

Cigarette Smoking? Never smoked Quit: former smoker Smokes less than daily Smokes daily

Alcohol Use? Yes No

Are you pregnant or nursing? Yes No

Review of Systems: Do you currently have any problems with the following? (please check all that apply)

<input type="checkbox"/> Bleeding	<input type="checkbox"/> Unintentional weight loss
<input type="checkbox"/> Healing	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Scarring	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Rash	<input type="checkbox"/> Joint aches
<input type="checkbox"/> Immunosuppression	<input type="checkbox"/> Muscle weakness
<input type="checkbox"/> Fever or chills	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Depression

Vaccination Status: (please circle)

For patients 50 and older, have you received a shingles vaccination? Yes No

For patients 65 and older, have you received a pneumonia vaccination? Yes No

Advance Care:

For patients 65 and older, do you have a healthcare proxy in the event you are unable to make your own medical decisions?

Yes No

If Yes, Designee's name: _____

Designee's phone number: _____ - _____ - _____

Pharmacy (all patients):

Name: _____

Mailing Address: _____

City _____ State _____ Zip _____

Phone: _____ - _____ - _____