



Patient Name: _____

Date of Birth: _____ **Gender:** (please circle one) **Male** **Female** **Transgender:** _____

Referred by a physician(whom?) _____

Past Medical History: (please check all that apply)

- | | | |
|--|---|---|
| <input type="radio"/> Anxiety | <input type="radio"/> Coronary Artery Disease | <input type="radio"/> Leukemia |
| <input type="radio"/> Arthritis | <input type="radio"/> Depression | <input type="radio"/> Lung Cancer |
| <input type="radio"/> Artificial joints | <input type="radio"/> Diabetes | <input type="radio"/> Lymphoma |
| <input type="radio"/> Asthma | <input type="radio"/> End Stage Renal Disease | <input type="radio"/> Pacemaker |
| <input type="radio"/> Atrial fibrillation | <input type="radio"/> GERD (Acid reflux) | <input type="radio"/> Prostate Cancer |
| <input type="radio"/> BPH (Benign Prostatic Hyperplasia) | <input type="radio"/> Hearing Loss | <input type="radio"/> Radiation Treatment |
| <input type="radio"/> Bone Marrow Transplantation | <input type="radio"/> Hepatitis | <input type="radio"/> Seizures |
| <input type="radio"/> Breast Cancer | <input type="radio"/> Hypertension | <input type="radio"/> Stroke |
| <input type="radio"/> Colon Cancer | <input type="radio"/> HIV/AIDS | <input type="radio"/> Valve Replacement |
| <input type="radio"/> COPD (Emphysema) | <input type="radio"/> Hypercholesterolemia | <input type="radio"/> None |
| <input type="radio"/> Other _____ | <input type="radio"/> Hyperthyroidism | |
| | <input type="radio"/> Hypothyroidism | |

Past Surgical History: (please check all that apply)

- | | |
|--|--|
| <input type="radio"/> Appendix Removed | <input type="radio"/> Kidney Removed (Right, Left) |
| <input type="radio"/> Bladder Removed | <input type="radio"/> Kidney Stone Removal |
| <input type="radio"/> Mastectomy (Right, Left, Bilateral) | <input type="radio"/> Kidney Transplant |
| <input type="radio"/> Lumpectomy (Right, Left, Bilateral) | <input type="radio"/> Organ Transplant _____ |
| <input type="radio"/> Breast Biopsy (Right, Left, Bilateral) | <input type="radio"/> Ovaries Removed: Endometriosis |
| <input type="radio"/> Breast Reduction | <input type="radio"/> Ovaries Removed: Cyst |
| <input type="radio"/> Breast Implants | <input type="radio"/> Ovaries Removed: Ovarian Cancer |
| <input type="radio"/> Colectomy: Colon Cancer Resection | <input type="radio"/> Prostate Removed: Prostate Cancer |
| <input type="radio"/> Colectomy: Diverticulitis | <input type="radio"/> Prostate Biopsy |
| <input type="radio"/> Colectomy: IBD | <input type="radio"/> TURP |
| <input type="radio"/> Gallbladder Removed | <input type="radio"/> Skin Biopsy |
| <input type="radio"/> Coronary Artery Bypass | <input type="radio"/> Basal Cell Cancer Surgery |
| <input type="radio"/> PTCA | <input type="radio"/> Squamous Cell |
| <input type="radio"/> Mechanical Valve Replacement | <input type="radio"/> Carcinoma Surgery |
| <input type="radio"/> Biological Valve Replacement | <input type="radio"/> Melanoma Surgery |
| <input type="radio"/> Heart Transplant | <input type="radio"/> Spleen Removed |
| <input type="radio"/> Joint Replacement, Knee (Right, Left, Bilateral) | <input type="radio"/> Testicles Removed (Right, Left, Bilateral) |
| <input type="radio"/> Joint Replacement, Hip (Right, Left, Bilateral) | <input type="radio"/> Hysterectomy: Fibroids |
| <input type="radio"/> Joint Replacement within last 2 years | <input type="radio"/> Hysterectomy: Uterine Cancer |
| <input type="radio"/> Kidney Biopsy | <input type="radio"/> None |
| <input type="radio"/> Other _____ | |

Patient Name: _____

Skin Disease History: (please check all that apply, include dates for any skin cancers)

- | | |
|--|---|
| <input type="radio"/> Acne | <input type="radio"/> Hay Fever/Allergies |
| <input type="radio"/> Actinic Keratoses | <input type="radio"/> Melanoma _____ |
| <input type="radio"/> Asthma | <input type="radio"/> Poison Ivy |
| <input type="radio"/> Basal Cell Skin Cancer _____ | <input type="radio"/> Precancerous Moles |
| <input type="radio"/> Blistering Sunburns | <input type="radio"/> Psoriasis |
| <input type="radio"/> Dry Skin | <input type="radio"/> Squamous Cell Skin Cancer _____ |
| <input type="radio"/> Eczema | <input type="radio"/> None |
| <input type="radio"/> Flaking or Itchy Scalp | |
| <input type="radio"/> Other _____ | |

Do you wear Sunscreen? Yes No
If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Family History (parents or siblings)

- | | | | | | |
|------------------------|---------------------------------|--------------------------|---------------------|---------------------------------|--------------------------|
| Melanoma | <input type="radio"/> Yes _____ | <input type="radio"/> No | High blood pressure | <input type="radio"/> Yes _____ | <input type="radio"/> No |
| Basal cell skin cancer | <input type="radio"/> Yes _____ | <input type="radio"/> No | Diabetes | <input type="radio"/> Yes _____ | <input type="radio"/> No |
| Eczema | <input type="radio"/> Yes _____ | <input type="radio"/> No | Psoriasis | <input type="radio"/> Yes _____ | <input type="radio"/> No |

Medications: (Please enter all current medications and supplements, including dosage)

Name of Medication	Why are you taking it?	Dosage (Mg, Gm)	Directions: Take_ pills _ time(s) a day

Pharmacy: Name: _____ Phone: _____
Street: _____ City: _____ Zip code: _____

Allergies:

What do you have an allergy to?	What is your reaction if you come in contact with it?

Social History: (Please check any that apply)

- | | | | |
|---|---|---|---|
| <u>Cigarette Smoking</u> | <u>Alcohol Use</u> | <u>Caffeine use</u> | <u>Exercise</u> |
| <input type="radio"/> Never smoked | <input type="radio"/> Never Drinks Alcohol | <input type="radio"/> Once a day | <input type="radio"/> Once a day |
| <input type="radio"/> Quit: former smoker | <input type="radio"/> Less than 1 drink per day | <input type="radio"/> A few times a week | <input type="radio"/> A few times a week |
| <input type="radio"/> Smokes some days | <input type="radio"/> 1-2 drinks per day | <input type="radio"/> A few times a month | <input type="radio"/> A few times a month |
| <input type="radio"/> Currently smokes everyday | <input type="radio"/> 3+ drinks per day | <input type="radio"/> Never | <input type="radio"/> Never |

Patient Signature: _____ **Date:** _____

Patient Name: (Please print) _____