Medical History

**Past Medical History:** (Please circle all that apply)
- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- Bone Marrow Transplantation
- BPH
- Breast Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Hearing Loss
- Hepatitis
- High Cholesterol
- Leukemia
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- Thyroid Problems

NONE

**Past Surgical History:** (Please circle all that apply)
- Appendix Removed
- Bladder Removed
- Mastectomy (Right, Left, Bilateral)
- Lumpectomy (Right, Left, Bilateral)
- Breast Biopsy (Right, Left, Bilateral)
- Breast Reduction
- Breast Implants
- Colectomy: Colon Cancer Resection
- Colectomy: Diverticulitis
- Colectomy: IBD
- Gallbladder Removed
- Coronary Artery Bypass
- Mechanical Valve Replacement
- Biological Valve Replacement
- Heart Transplant
- Joint Replacement, Knee (Right, Left, Bilateral)
- Joint Replacement, Hip (Right, Left, Bilateral)
- Joint Replacement within last 2 years
- Kidney Biopsy (Nephrectomy)
- Kidney Removed (Right, Left)
- Kidney Stone Removal
- Kidney Transplant
- Ovaries Removed: Endometriosis
- Ovaries Removed: Cyst
- Ovaries Removed: Ovarian Cancer
- Prostate Removed: Prostate Cancer
- Prostate Biopsy
- TURP (Prostate Removal)
- Spleen Removed
- Testicles Removed (Right, Left, Bilateral)
- Hysterectomy: Fibroids
- Hysterectomy: Uterine Cancer

NONE

**Skin Disease History:** (Please circle all that apply)
- Acne
- Actinic Keratoses
- Asthma
- Basal Cell Skin Cancer
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking or Itchy Scalp
- Hay Fever/Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Skin Cancer

NONE

**Do you wear sunscreen?**
- Yes
- No
- If yes, what SPF? ________________

**Do you tan in a tanning salon?**
- Yes
- No
- If yes, which relative? ________________

**Medications:** (please enter all current medications)
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________

**Allergies:** (please enter all allergies)
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
Alcohol Use (EtOH):
Currently Smokes       EtOH - NONE
Has smoked in the past EtOH - less than 1 drink per day
Never smoked          EtOH - 1-2 drinks per day
Former Smoker         EtOH - 3 or more drinks per day
Other: __________________________________________________________________________________

Family History: (Only first degree relatives)
__________________________________________________________________________________________
__________________________________________________________________________________________

Preferred Language: __________________________ Race: _________________________ Ethnic Group: _______________________

*Preferred Pharmacy Name: ____________________________________________________________________________________

Phone #: __________________________ City or Zip Code: _______________________

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Abdominal Pain</td>
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<tr>
<td>Anxiety</td>
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<td>Bleeding Problems</td>
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<td>Bloody Stool</td>
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<td>Blurry Vision</td>
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<td>Changing Mole</td>
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<td>Chest Pain</td>
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<td>Cough</td>
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<td>Depression</td>
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<td>Fever or Chills</td>
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<td>Headaches</td>
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<td>Hay Fever</td>
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<td>Joint Aches</td>
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<td>Muscle Weakness</td>
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<td>Neck Stiffness</td>
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<td>Night Sweats</td>
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<td>Rash</td>
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<td>Seizures</td>
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<td>Shortness of Breath</td>
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<tr>
<td>Sore Throat</td>
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<td>Thyroid Problems</td>
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<td>Unintentional Weight Gain</td>
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<tr>
<td>Wheezing</td>
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</tbody>
</table>

Other Symptoms: ________________________________________________________________________________

Alerts: (Please circle all that apply)

Allergy to Adhesive       MRSA
Allergy to Lidocaine      Pacemaker
Allergy to Topical Antibiotics Require antibiotics prior to surgical procedure
Artificial heart valve    Rapid heartbeat with epinephrine
Artificial joint replacement Are you pregnant or currently trying to get pregnant?
Blood thinners            Are you pregnant?
Defibrillator             Are you breast feeding?

Other Symptoms: ________________________________________________________________________________

Signature: ___________________________ Date: ___________________________