Medical History

Past Medical History: (Please circle all that apply)

Anxiety	Coronary Artery Disease	HIV/AIDS
Arthritis	Depression	High Cholesterol
Asthma	Diabetes	Leukemia
Atrial Fibrillation	End Stage Renal Disease	Prostate Cancer
Bone Marrow Transplantation	GERD	Radiation Treatment
BPH	Hearing Loss	Seizures
Breast Cancer	Hepatitis	Stroke
COPD	High Blood Pressure	Thyroid Problems

NONE
Other: _____

Past Surgical History: (Please circle all that apply)

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

NONE
Other: _____

Skin Disease History: (Please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	

NONE
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? _____

Medications: (please enter all current medications)

_____ _____
_____ _____
_____ _____

Allergies: (please enter all allergies)

_____ _____
_____ _____
_____ _____

Alcohol Use (EtOH):

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker
Other: _____

EtOH - NONE
EtOH - less than 1 drink per day
EtOH - 1-2 drinks per day
EtOH - 3 or more drinks per day

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)

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

Other Symptoms: _____

Alerts: (Please circle all that apply)

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

Other Symptoms: _____

Signature: _____ Date: _____