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| **Name: Date of Birth: / /** **Last First Middle****Primary Care Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_** |
| **History or current problem with any of the following? (Please check all that apply)** |
| Problems with bleeding | * Yes
 | * No
 | HIV/AIDS | * Yes
 | * No
 |  | Allergy to Adhesive | * Yes
 | * No
 |
| Problems with healing | * Yes
 | * No
 | High Cholesterol | * Yes
 | * No
 |  | Allergy to Lidocaine | * Yes
 | * No
 |
| Problems with scarring (*hypertrophic or keloid)* | * Yes
 | * No
 | Immunosuppression | * Yes
 | * No
 |  | Allergy to topical antibiotic ointments | * Yes
 | * No
 |
| Abdominal Pain | * Yes
 | * No
 | Joint Aches/Pain | * Yes
 | * No
 |  | Artificial Heart Valves | * Yes
 | * No
 |
| Anxiety | * Yes
 | * No
 | Joint Replacement | * Yes
 | * No
 |  | Artificial Joints in the last 2 yrs | * Yes
 | * No
 |
| Bloody Stool/Urine | * Yes
 | * No
 | Leukemia | * Yes
 | * No
 |  |  |  |  |
| Bone Marrow Transplant | * Yes
 | * No
 | Liver Disease | * Yes
 | * No
 |  | Defibrillator | * Yes
 | * No
 |
| Cancer | * Yes
 | * No
 | Lymphoma | * Yes
 | * No
 |  | Pacemaker | * Yes
 | * No
 |
| Chest Pain | * Yes
 | * No
 | Muscle Weakness | * Yes
 | * No
 |  | MRSA | * Yes
 | * No
 |
| COPDDepression Diabetes | * Yes
* Yes
* Yes
 | * No
* No
* No
 | Night SweatsProstate CancerRadiation Treatment | * Yes
* Yes
* Yes
 | * No
* No
* No
 |  | Premedication prior to proceduresCurrently pregnant or planning a pregnancy | * Yes
* Yes
 | * No
* No
 |
| Elevated Blood Pressure | * Yes
 | * No
 | Rash/Hives | * Yes
 | * No
 |  | Rapid heartbeat with epinephrine | * Yes
 | * No
 |
| End Stage Renal Disease | * Yes
 | * No
 | Seizures | * Yes
 | * No
 |  | Transplant | * Yes
 | * No
 |
| Fever/Chills | * Yes
 | * No
 | Sore Throat | * Yes
 | * No
 |  |  |  |  |
| Heart Attack  | * Yes
 | * No
 | Thyroid Disease | * Yes
 | * No
 |  |  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Headaches | * Yes
 | * No
 | Unintentional Weight Loss | * Yes
 | * No
 |  |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Hearing Loss | * Yes
 | * No
 | Wheezing/Shortness of breath | * Yes
 | * No
 |  |  |  |  |
| Hepatitis A/B/C | * Yes
 | * No
 |  |  |  |  |  |  |  |
| **Have you had any of the following conditions? (Please check all that apply)** |
| * Acne
* Blistering Sunburns
* Dry Skin
* Eczema
* Flaking or Itchy Scalp
* Hay Fever/Allergies
* Psoriasis
* Poison Ivy
 | * Actinic Keratosis (pre-skin cancer)
* Precancerous Moles
* Squamous Cell Skin Cancer
* Basal Cell Skin Cancer
* Melanoma

Year  Other  |  Have you ever tested positive for TB?Are you a current smoker?Are you a former smoker?Do you drink alcohol?Any illicit drug use?Do you have any environmental allergies? Please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Yes ☐ No
* Yes ☐ No
* Yes ☐ No
* Yes ☐ No
* Yes ☐ No
* Yes ☐ No
 |
|  | **Are you currently taking any of the blood thinners? (Check from list below)** |
| **Do you have a family history of melanoma?*** Yes ☐ No

If yes, which relative(s)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you wear sunscreen?* Yes ☐ No
 | **Vaccinations:** Have you received your flu vaccination for the current year?* Yes ☐ No
 | * Aspirin
* Cilostazol (Pletal)
* Coumadin (Warfarin)
* Dipyridamole (Aggrenox)
* Eliquis
* Plavix (Clipidogrel)
* Ticagrelor (Brilinta)
* Ticlodipin (Ticlid)
* Xarelto
 |
| Have you received your pneumonia vaccination?* Yes ☐ No

Have you received your Shingles vaccination?* Yes ☐ No
 |
|



**Name: Date of Birth: / /**

**Last First Middle**

**Preferred Pharmacy – Do we have your permission to import your pharmacy records to help coordinate care? YES or NO**

**Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City or Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **\*Any Medication Allergies?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Medications**(List All) |
| **Medication** | **Dosage** | **Frequency** | **Route** |
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| **Medical Problems**(Please list any medical problems for which you are regularly treated) |
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| **Surgical History** |
| **Surgery** | **Date** |
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Signature: Date:

Printed Name: