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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 |
| COPD  Depression  Diabetes | * Yes * Yes * Yes | * No * No * No | Night Sweats  Prostate Cancer  Radiation Treatment | * Yes * Yes * Yes | | * No * No * No |  | Premedication prior to procedures  Currently 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 | | |
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**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: