Date: ______________________________

Patient Name: ______________________________

Patient Date of Birth: ______________________

Can we leave a message with clinical information (such as a test result) on the telephone numbers you have given us? ___________

Name of your Primary Care Provider: _________________________________

Please list the medications you currently take (Please include dose if known):

If no medications, please write "NONE".

____

____

____

____

DO YOU SMOKE? ___YES ___NO [If currently NO, Have you ever been a smoker? ___YES ___ NO]

What Pharmacy do you use?

Please include address [street &/or town] if known:

Please check any of the following medical conditions that you currently have:

☐ Anxiety	☐ HIV / AIDS
☐ Arthritis	☐ Hypercholesterolemia (High Cholesterol)
☐ Asthma	☐ Hyperthyroidism
☐ Atrial Fibrillation (Irregular Heartbeat)	☐ Hypothyroidism
☐ Bone Marrow Transplantation	☐ Leukemia
☐ Coronary Artery Disease	☐ Lung Cancer
☐ Depression	☐ Lymphoma
☐ Diabetes	☐ Prostate Cancer
☐ End Stage Renal Disease	☐ Radiation Treatment
☐ Hearing Loss	☐ Seizures
☐ Hepatitis	☐ Stroke
☐ Hypertension (High Blood Pressure)	

OTHER:

Check here if there are None ☐

PLEASE TURN PAGE OVER…

Past Surgeries

Have you had any surgeries on the following organs?

☐ Appendix (Appendectomy)	☐ Heart : Mechanical Valve Replacement
☐ Bladder (Cystectomy)	☐ Heart : Biological Valve Replacement
☐ Breast (Cancer, Lumpectomy)	☐ Heart : Heart Transplant
☐ Breast (Cancer, Mastectomy)	☐ Skin : Skin Biopsy
☐ Colon (Colectomy) : Colon Cancer Resection	☐ Skin : Basal Cell Carcinoma
☐ Colon (Colectomy) : Diverticulitis	☐ Skin : Squamous Cell Carcinoma
☐ Colon (Colectomy) : Inflammatory Bowel Disease	☐ Skin : Melanoma
☐ Gallbladder (Cholecystectomy)	☐ Spleen (Splenectomy)
☐ Heart : Coronary Artery Bypass Surgery	☐ Testicles (Orchidectomy)
☐ Heart : PTCA	☐ Uterus (Hysterectomy) : Uterine Cancer

OTHER:

Check here if there are None ☐

Have you had any of the following skin conditions:

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

The following questions for use by the US government. You have the right to decline to answer them.

What is your preferred language: ☐ English ☐ Other: ___________________________

Race: ______________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

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, what relative(s)? ____

Do you have any allergies? ___ YES ____NO

If yes, please list here (specifically include Medicines, Latex or products & Food allergies):

Allergy:__________________	Allergy:__________________	Allergy:__________________
Describe Reaction:	Describe Reaction:	Describe Reaction:
☐ Anaphylaxis	☐ Anaphylaxis	☐ Anaphylaxis
☐ Angioedema (Facial Swelling)	☐ Angioedema (Facial Swelling)	☐ Angioedema (Facial Swelling)
☐ Diarrhea	☐ Diarrhea	☐ Diarrhea
☐ Fatigue	☐ Fatigue	☐ Fatigue
☐ GI upset	☐ GI upset	☐ GI upset
☐ Hives	☐ Hives	☐ Hives
☐ Liver toxicity	☐ Liver toxicity	☐ Liver toxicity
☐ Rash	☐ Rash	☐ Rash

List more allergies here, the nursing staff will go over them with you:

____

____

____

Please check any of the following statements that are applicable to you:

- ❑ MVP (Mitral Valve Prolapse)
- ❑ Have a pacemaker
- ❑ Have a defibrillator
- ❑ Have an artificial heart valve
- ❑ Premedicate prior to procedures
- ❑ Have an allergy to adhesive
- ❑ Have an allergy to topical antibiotic ointments
- ❑ Take blood thinners (e.g. aspirin, Coumadin, etc.)
- ❑ Allergic to lidocaine
- ❑ Rapid heart beat with epinephrine
- ❑ Get yeast infection with antibiotics
- ❑ Have GI upset with antiobiotics

IF YOU ARE A NEW PATIENT, OR HAVE NOT BEEN TO OUR PRACTICE IN OVER 3 YEARS,
PLEASE TURN OVER & COMPLETE THE QUESTIONS ON THE BACK.

Review of Systems

Name: ______________________________ Do you have…	Yes	No
problems with bleeding		
problems with scarring (hypertrophic or keloid)		
changing mole		
cough		
fever or chills		
Hay fever		
shortness of breath		
thyroid problems		