

Patient Name: _____ **Date:** _____ **Acct:** _____
 (For Office Use Only)

PATIENT DEMOGRAPHICS

Date of Birth: _____ **Gender:** Male Female **Preferred Language:** _____

Race (Please check one):

- White
- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- Other Race

Ethnic Group (Please check one):

- Hispanic or Latino
- Not Hispanic or Latino

PAST MEDICAL HISTORY (Please check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> GERD (Acid Reflux) | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> BPH (Enlarged Prostate) | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Bone Marrow Transplantation | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD (Chronic Lung Disease) | <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> None |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hyperthyroidism | |
| <input type="checkbox"/> Other: _____ | | |

PAST SURGICAL HISTORY (Please check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Appendix Removed | <input type="checkbox"/> Biological Valve Replacement | <input type="checkbox"/> Skin Biopsy |
| <input type="checkbox"/> Bladder Removed | <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Basal Cell Cancer Surgery |
| <input type="checkbox"/> Mastectomy <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Knee Replacement <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Squamous Cell Carcinoma Surgery |
| <input type="checkbox"/> Lumpectomy <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Hip Replacement <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Melanoma Surgery |
| <input type="checkbox"/> Breast Biopsy | <input type="checkbox"/> Kidney Biopsy | <input type="checkbox"/> Spleen Removed |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Kidney Removed <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Testicles Removed <input type="checkbox"/> Right <input type="checkbox"/> Left |
| <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Kidney Stone Removal | <input type="checkbox"/> Hysterectomy: Fibroids |
| <input type="checkbox"/> Colectomy: Colon Cancer Resection | <input type="checkbox"/> Kidney Transplant | <input type="checkbox"/> Hysterectomy: Uterine Cancer |
| <input type="checkbox"/> Colectomy: Diverticulitis | <input type="checkbox"/> Ovaries Removed: Endometriosis | <input type="checkbox"/> None |
| <input type="checkbox"/> Colectomy: IBD | <input type="checkbox"/> Ovaries Removed: Cyst | |
| <input type="checkbox"/> Gallbladder Removed | <input type="checkbox"/> Ovaries Removed: Ovarian Cancer | |
| <input type="checkbox"/> Coronary Artery Bypass | <input type="checkbox"/> Prostate Removed: Prostate Cancer | |
| <input type="checkbox"/> PTCA (Angioplasty) | <input type="checkbox"/> Prostate Biopsy | |
| <input type="checkbox"/> Mechanical Valve Replacement | <input type="checkbox"/> TURP (Prostate Surgery) | |
| <input type="checkbox"/> Other: _____ | | |

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SKIN DISEASE HISTORY (Please check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Actinic Keratoses | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever / Allergies | <input type="checkbox"/> None |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Melanoma | |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Poison Ivy | |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Precancerous Moles | |
| <input type="checkbox"/> 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(s)? _____
 Any other family history: _____

PHARMACY & MEDICATIONS (Please enter all current medications, dosage and frequency)

Pharmacy Name: _____ Phone #: _____ Address: _____

Medication / Dosage / Frequency	Medication / Dosage / Frequency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

None

ALLERGIES (Please enter all allergies)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

None

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SOCIAL HISTORY (Please check all that apply)

Alcohol Use:

- None
- Less than 1 drink a day
- 1-2 drinks a day
- 3 or more drinks a day

Cigarette Smoking:

- Never smoked
- Quit: Former smoker
- Smokes less than daily
- Smokes daily

REVIEW OF SYSTEMS: Are you currently experiencing any of the following? (Please check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergy to Adhesive | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Fever or Chills | <input type="checkbox"/> Neck Stiffness |
| <input type="checkbox"/> Pregnancy or Planning a Pregnancy | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Swollen Lymph Nodes | <input type="checkbox"/> Unintentional Weight Loss | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Problems with Bleeding | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Problems with Healing | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Problems with Scarring
(Hypertrophic or Keloid) | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Immunosuppression | <input type="checkbox"/> Bloody Stool | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Bloody Urine | |
| <input type="checkbox"/> Other Symptoms: _____ | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> None | | |

ALERTS: Are you currently experiencing any of the following? (Please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Allergy to Lidocaine | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Allergy to topical Antibiotic Ointment | <input type="checkbox"/> Premedication prior to procedure |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Rapid Heartbeat with Epinephrine |
| <input type="checkbox"/> Defibrillator | |
| <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> None | |