

Name: _____
Last, First

Date: ____ / ____ / ____
Date Of Birth: ____ / ____ / ____

Past Medical History: (mark all that apply)

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> GERD | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hepatitis - A/B/C | <input type="checkbox"/> Leukemia | |
| <input type="checkbox"/> Bone Marrow Transplantation | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Lung Cancer | |
| <input type="checkbox"/> BPH (prostate) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Lymphoma | |
| | | | <input type="checkbox"/> Prostate Cancer | |
- Other (specify) _____
- None

Past Surgical History: (mark all that apply)

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

Skin Disease History: (mark all that apply)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Precancerous Moles |
| <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Melanoma Skin Cancer | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Eczema | <input type="checkbox"/> Poison Ivy | <input type="checkbox"/> Squamous Cell Skin Cancer |
| | <input type="checkbox"/> Flaking or Itchy Scalp | | |
- Other _____
- None

Do you have a family history of MELANOMA (NOT the same as basal cell or squamous cell carcinoma)? Yes No

If YES to melanoma, which relative(s)? _____

If YES to melanoma, any other family history (breast, ovarian, pancreatic or prostate cancers)?

Have you had a Pneumonia Vaccine? Yes/NO (circle one) If Yes When? _____

Height _____ Weight _____ BMI _____

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Medications: (enter all current medications and strengths) None

Medication:	Strength:

Medication:	Strength:

Medication:	Strength:

Drug Allergies: (do they cause anaphylaxis, angioedema, diarrhea, fatigue, GI upset, hives, liver toxicity, or rash?)

No Known Drug Allergies

Latex

Social History: (mark all that apply)

Illicit Drug Use:

Drug Use

IV Drug Use

Cigarette Smoking (REQUIRED):

Current every day smoker

Current some day smoker

Former smoker

Never smoker

Alcohol (EtOH) Use:

None

Less than 1 drink a day

1-2 Drinks per day

3 or more drinks per day

How many times in the past year have you had 5 (for men under age 65) or 4 (for women and all adults older than 65 years) or more drinks in a day? _____

Other _____

Review of Systems: Are you currently experiencing any of the following? (Circle all that apply.)

Problems with bleeding	Fever or chills	Bloody Stool	Cough
Problems with healing	Night sweats	Bloody Urine	Shortness of Breath
Problems with scarring	Unintentional weight loss	Joint Aches	Wheezing
Rash	Thyroid problems	Muscle Weakness	Prone to vasovagal (Fainting)
Immunosuppression	Sore throat	Neck Stiffness	
Hay fever	Blurry vision	Headaches	
Chest Pain	Abdominal Pain	Seizures	

Other Symptoms: _____

Alerts: Are you currently using or experiencing any of the following? (Please check yes or no for the following)

Allergy to adhesive	<input type="checkbox"/> Yes	Premedication prior to procedures	<input type="checkbox"/> Yes
Allergy to lidocaine	<input type="checkbox"/> Yes	Rapid heart beat with epinephrine	<input type="checkbox"/> Yes
Allergy to topical antibiotic ointments	<input type="checkbox"/> Yes	Pregnancy or planning a pregnancy	<input type="checkbox"/> Yes
Allergy to epinephrine	<input type="checkbox"/> Yes	HIV Positive	<input type="checkbox"/> Yes
Artificial heart valve	<input type="checkbox"/> Yes	Currently on Biologics	<input type="checkbox"/> Yes
Artificial Joints within past 2 years	<input type="checkbox"/> Yes	Deaf	<input type="checkbox"/> Yes
Blood thinners	<input type="checkbox"/> Yes	Legally blind	<input type="checkbox"/> Yes
Defibrillator	<input type="checkbox"/> Yes	Allergy to latex	<input type="checkbox"/> Yes
MRSA	<input type="checkbox"/> Yes	History of cold sores	<input type="checkbox"/> Yes
Pacemaker or other electrical implanted device	<input type="checkbox"/> Yes	Currently breastfeeding	<input type="checkbox"/> Yes

Other Symptoms: _____

PHARMACY (You may ALSO list your mail-order pharmacy - include PHONE and FAX number)

Name _____ Zip Code _____

Address (or major cross-roads if not known): _____

Are you interested in any cosmetic products and/or procedures? Yes No

(Peels, injections, lasers, etc.)