PATIENT HISTORY

This is confidential medical information.
Accurate and complete medical information is needed to help us provide optimal care.

Black Ink Only

Patient's Name: _____ Todays Date: _____

TODAY'S VISIT

What is the reason for today's appointment?

_____

MEDICATIONS (list medications you are currently taking, include injectables, herbals and over-the-counter meds):

INCLUDE STRENGTH, DOSAGE AND FREQUENCY

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

MEDICAL HISTORY

Have you ever had skin cancer? If yes, please list type, date and location:

_____

_____

Have you previously been diagnosed with any chronic skin conditions? If yes, please list:

_____

Have you ever had the following? **(Check all that apply)**

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Cancer, type: _____
- ☐ Depression
- ☐ Diabetes
- ☐ Genetic disease, type: _____
- ☐ GI/bowel disease, type: _____
- ☐ Glaucoma
- ☐ Heart attack/disease
- ☐ Hepatitis, type: _____
- ☐ High blood pressure
- ☐ Lupus
- ☐ Multiple sclerosis
- ☐ Organ transplant, type: _____
- ☐ Psychiatric disease
- ☐ Radiation, explain: _____
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis

Other chronic or current medical condition(s) not listed _____

_____

Do you have any of the following? **(Check all that apply)**

☐ Pacemaker or defibrillator ☐ Prosthesis ☐ Artificial heart valve ☐ Joint replacement

Do you require antibiotics prior to surgical or dental procedures? ☐ Yes ☐ No

Are you pregnant or planning pregnancy? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

Please complete front and back of form in its entirety (or both pages)

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Patient's Name: _____

ALLERGIES TO MEDICATIONS (list medication and type of reaction):

_____ _____

_____ _____

HOSPITILIZATIONS / SURGERIES

Have you had any surgeries or been hospitalized in the last 12 months? ☐ No ☐ Yes, please list

_____

_____

FAMILY HISTORY (please check all that apply)

	mom	dad	sibling	child
Skin cancer (non-melanoma type)				
Melanoma				
Asthma				
Allergies				
Eczema				

VACCINE HISTORY

Have you Received?	Approx Date Last Received
Shingles Vaccine	
Influenza (Flu Shot)	
Pneumonia	

Do you have an advanced care plan or a surrogate decision maker for your medical wishes? ☐ Yes ☐ No

Name of Surrogate: _____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No Current every day smoker? ☐ Yes ☐ No Current some day smoker? ☐ Yes ☐ No

Smoker, current status unknown ☐ Yes ☐ No Unknown if ever smoked ☐ Yes ☐ No

Are you a former smoker? ☐ Yes ☐ No

How long were you a smoker? _____ What year did you quit? _____

Do you use other tobacco products? ☐ Yes ☐ No

Would you like information on smoking cessation? ☐ Yes ☐ No

Have you ever used tanning beds? ☐ No ☐ Yes, in the past ☐ Yes, Current frequent ☐ Yes, Current occasionally

Have you ever had a blistering sunburn? ☐ Yes ☐ No

REVIEW OF SYSTEMS

Please check any of the symptoms you are ***currently* experiencing**:

☐ Weight loss (unintentional)
☐ Fever
☐ Fatigue
☐ Nausea/vomiting
☐ Sore throat
☐ Abdominal pain
☐ Swollen lymph nodes
☐ Bleeding problem
☐ Changes in vision
☐ Cough
☐ Shortness of breath
☐ Muscle/Joint pain
☐ Chest pain
☐ Allergy symptoms
☐ Pain urinating
☐ Depression / Anxiety

☐ **PLEASE CHECK HERE IF YOU ARE IN YOUR USUAL STATE OF GOOD HEALTH**

Please complete front and back of form in its entirety (or both pages)