PATIENT HISTORY FORM

Name:_____ **Date Of Birth:**_____

Prefer to be called: _____

Primary Care Provider: _____**Did they refer you to this office?** Yes No

Preferred Pharmacy:_____

Current Medical Problem You Are Here For Today: _____

Personal Past Medical History: (Please circle all that apply)

Anxiety
Arthritis, Rheumatoid or Psoriatic
Artificial Joints (year of placement):_____
Asthma
Bacterial Endocarditis
Blood Clots
Cancer (type):_____
COPD
Coronary Artery Disease
Depression
Diabetes
Food Allergies
Gastrointestinal Disease:_____
GERD
Heart Attack
Heart Failure
Heart Murmur
Heart Valve Replacement
Hepatitis/Liver Disease
History of Organ Transplant (organ):_____
High Blood Pressure
High Cholesterol
HIV
Irregular Heartbeat
Kidney Disease
Migraine Headaches
RadiationTreatments
Seasonal Allergies
Seizure/Epilepsy
Stroke
Thyroid Disease

NONE OF THE ABOVE

Other:_____
Past Surgical History and Hospitalizations: (List all)_____
_____

If under 2 years of age- Pediatric History:
Gestational age at birth (in weeks):_____ Birth weight:_____
Any complications with delivery or medical issues after birth:_____

Skin History: (Please circle all that apply)

Acne
Actinic Keratosis
Atypical Moles
Basal Cell Skin Cancer
Cold Sores
Dry Skin
Eczema
Flaking or Itching Scalp
Keloid Scars
Melanoma Skin Cancer
Psoriasis
Squamous Cell Skin Cancer
Sunburn (blistering)
NONE OF THE ABOVE

Other:_____
(If you are a new patient, please list the location & type of all skin cancers you have had)

Do you wear sunscreen? Yes No If yes, SPF?_____ Have you used indoor tanning? Currently Former Never

Do you have a family history of melanoma? YES NO
If yes, which relative(s)? _____

Do you have a family history of nonmelanoma skin cancer (basal cell or squamous cell)? YES NO
If yes, which relatives(s)?_____

Any other family history of skin conditions (eczema, psoriasis, atypical moles, autoimmune conditions, etc)? YES NO
If yes, which relative(s)?_____

Medications: (Please enter all current medications including vitamins, supplements, birth control, IUD) **No Medications**

_____
_____
_____

Do you have allergies to medications? Yes No **No Allergies**
If yes, please list and give type of reaction:_____
_____

Do you smoke? (circle one) Current (____Packs per day) Former Never

Number of alcoholic drinks per day (circle one)
None Less than 1 per day 1-2 per day 3 or more per day

Occupation: _____

Do you receive a yearly influenza vaccine? YES NO

If 65 years or older, have you received the pneumonia vaccine? YES NO

Do you have an Advanced Directive (Living Will)? YES NO

Are you currently experiencing? (please circle all that apply)

Problems with bleeding
Fever or Chills
Unintentional weight loss
Problems with scarring/keloids
Night sweats
Joint Pain
None

Alerts: (Please circle all that apply)

Allergy to Adhesive
Allergy to Lidocaine
Allergy to Topical Antibiotics
Blood Thinner
Rapid Heart Rate With Epinephrine
Require Antibiotics Prior to Surgical Procedure
MRSA
Pacemaker
Bone Marrow Transplant
Defribillator
Healing Problems
Other_____

Are you ____pregnant, ____nursing, ____planning pregnancy (check if yes)

Patient Signature: _____Date: _____
Name of person completing this form if other than patient: (please print) _____
Relationship to Patient: (circle one) Parent Legal Guardian Other_____