PATIENT HISTORY FORM

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

Prefer to be called: _____

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

Occupation: _____

Current Medical Problem You Are Here For Today: _____

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

Anxiety/Depression	Gastrointestinal Disease:_____	HIV
Arthritis, Rheumatoid or Psoriatic	GERD	Irregular Heartbeat
Artificial Joints (year of placement):_____	Heart Attack	Kidney Disease
Asthma/COPD	Heart Failure	Migraine Headaches
Bacterial Endocarditis	Heart Murmur	RadiationTreatments
Blood Clots	Heart Valve Replacement	Seasonal Allergies
Cancer (type):_____	Hepatitis/Liver Disease	Seizure/Epilepsy
Coronary Artery Disease	History of Organ Transplant (organ):_____	Stroke
Diabetes	High Blood Pressure	Thyroid Disease
Food Allergies	High Cholesterol	**NONE OF THE ABOVE**

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

Skin History: (Please circle all that apply)

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

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

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)?_____

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

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:_____

_____

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

Number of alcoholic drinks per day (circle one)

None Less than 1 per day 1-2 per day 3 or more per day

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

Preferred Pharmacy:_____

Alerts: (Please circle all that apply)

Allergy to Adhesive or Lidocaine
Allergy to Topical Antibiotics
Blood Thinner
Bone Marrow Transplant
Defibrillator
Healing Problems
MRSA
Pacemaker
Pregnant/nursing or planning Future Pregnancy
Rapid Heart Rate With Epinephrine
Require Antibiotics Prior To Surgical Procedure
Other_____

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

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

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

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:_____

Patient Signature: _____Date: _____

Name of person completing this form if other than patient: (please print) _____

Relationship to Patient: (circle one) Parent Legal Guardian Other_____