**PATIENT NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DATE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR VISIT** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT PAST MEDICAL HISTORY**

|  |  |  |
| --- | --- | --- |
|  |  | **DETAILS** |
| **-No Pertinent Past Medical History** | □ |  |
| **Asthma** | □ |  |
| **Bleeding Disorder** | □ |  |
| **Breast Cancer** | □ |  |
| **Cancer** | □ |  |
| **Chest Pain/tightness** | □ |  |
| **Diabetes** | □ |  |
| **Eczema** | □ |  |
| **Heart Disease** | □ |  |
| **High Blood Pressure** | □ |  |
| **Hives** | □ |  |
| **Kidney Stones** | □ |  |
| **Other** | □ |  |
| **Stroke** | □ |  |
| **Thyroid Disorder** | □ |  |
| **Tuberculosis** | □ |  |
| **Ulcers** | □ |  |
| **Xray Therapy** | □ |  |

**IMPORTANT INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **DATE** | **DETAILS** |
| **Currently Pregnant** | □ |  |  |
| **Planning Pregnancy, How soon?** | □ |  |  |
| **Defibrillator** | □ |  |  |
| **Knee replacement** | □ |  |  |
| **Hip replacement** | □ |  |  |
| **Valve replacement** | □ |  |  |
| **HIV History** | □ |  |  |
| **Hepatitis** | □ |  |  |
| **Heart Murmur** | □ |  |  |
| **Pacemaker** | □ |  |  |
| **Transplants** | □ |  |  |
| **Latex Allergy** | □ |  |  |
| **Other** | □ |  |  |
| **None** | □ |  |  |

**FAMILY HISTORY**

|  |  |  |
| --- | --- | --- |
|  |  | **NOTES** |
| **-No Relevant Family History** | □ |  |
| **-Unknown – Adopted** | □ |  |
| **Autoimmune Disorders** | □ |  |
| **Cancer** | □ |  |
| **Other** | □ |  |
| **Skin Cancer** | □ |  |

**HISTORY OF SKIN CANCER**

□ None □ Personal history of skin cancer □ Personal history of melanoma □ Family history of skin cancer

**PATIENT PAST SURGERIES/ HOSPITALIZATIONS (IF NONE, PLEASE WRITE NONE)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **SURGERY/HOSPITALIZATON** | **DATE** | **NOTES** |
| **1** |  |  |  |
| **2** |  |  |  |
| **3** |  |  |  |
| **4** |  |  |  |
| **5** |  |  |  |
| **6** |  |  |  |
| **7** |  |  |  |
| **8** |  |  |  |
| **9** |  |  |  |
| **10** |  |  |  |

**SMOKING STATUS**

|  |  |
| --- | --- |
| **Smoking Status** |  |
| **Started** |  |
| **Ended** |  |
| **Cessation Counseling (OFFICE ONLY)** |  |

**PATIENT ALLERGIES (IF NONE, PLEASE WRITE NONE)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **ALLERGY** | **REACTION** | **NOTES** |
| **1** |  |  |  |
| **2** |  |  |  |
| **3** |  |  |  |
| **4** |  |  |  |
| **5** |  |  |  |
| **6** |  |  |  |
| **7** |  |  |  |
| **8** |  |  |  |
| **9** |  |  |  |
| **10** |  |  |  |

**PATIENT CURRENT MEDICATIONS (IF NONE, PLEASE WRITE NONE)**

|  |  |  |
| --- | --- | --- |
|  | **DRUG** | **DOSAGE** |
| **1** |  |  |
| **2** |  |  |
| **3** |  |  |
| **4** |  |  |
| **5** |  |  |
| **6** |  |  |
| **7** |  |  |
| **8** |  |  |
| **9** |  |  |
| **10** |  |  |

**MEDICAL HISTORY VERIFICATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **All information provided above is accurate and complete to the best of my knowledge** | **PATIENT INITIALS** | **PARENT OR GUARDIAN INITIALS** | **DATE** |
|  |  |  |