Patient Name: _____ **DOB:** ____ / ____ / ____
FIRST M.I. LAST

Smoking Status: ☐ Current smoker ☐ Former smoker ☐ Never smoked **Preferred Language:** _____

Race: _____ **Ethnic Group:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ I choose not to specify

Pharmacy: _____
NAME TOWN PHONE NUMBER

Primary Care Provider: _____ **Reason for Todays Visit:** _____

Past Medical History: *(please check all that apply)*

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Autism
- ☐ Bipolar
- ☐ Bone marrow transplant
- ☐ BPH
- ☐ Breast cancer
- ☐ Colon cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Developmental Disability
- ☐ Diabetes
- ☐ End stage renal disease
- ☐ GERD
- ☐ Hay Fever/Allergies
- ☐ Hearing loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung cancer
- ☐ Lymphoma
- ☐ Prostate cancer
- ☐ Radiation treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Pneumonia Vaccine
- ☐ Shingles Vaccine

OTHER:

Past Surgical History: *(please check all that apply)*

- ☐ Breast biopsy
- ☐ Lumpectomy: ☐ right ☐ left ☐ bilateral
- ☐ Mastectomy: ☐ right ☐ left ☐ bilateral
- ☐ Colectomy: ☐ colon cancer ☐ diverticulitis
- ☐ Gallbladder removed
- ☐ Heart valve replacement, type of valve _____
- ☐ Coronary artery bypass
- ☐ Heart transplant
- ☐ Angioplasty (PTCA)
- ☐ Hip replacement: ☐ right ☐ left ☐ bilateral
- ☐ Knee replacement: ☐ right ☐ left ☐ bilateral
- ☐ Kidney transplant
- ☐ Kidney removed
- ☐ Liver transplant
- ☐ Liver shunt
- ☐ Ovaries removed: ☐ endometriosis ☐ cancer ☐ cyst
- ☐ Prostate removed: ☐ cancer ☐ TURP
- ☐ Spleen removed
- ☐ Hysterectomy: ☐ fibroids
- ☐ Hysterectomy: ☐ uterine cancer ☐ cervical cancer

OTHER SURGERIES:

Skin Disease History: *(please check all that apply)*

DO YOU HAVE A FAMILY HISTORY OF MELANOMA? ☐ YES ☐ NO ***If yes, which relative(s)?:***

- ☐ Acne
- ☐ Actinic keratosis
- ☐ Basal cell skin cancer
- ☐ Dry skin
- ☐ Eczema
- ☐ Hay fever/allergies
- ☐ Melanoma
- ☐ Poison ivy
- ☐ Precancerous moles
- ☐ Psoriasis
- ☐ Squamous cell skin cancer
- ☐ Sunscreen SPF ____ # Sunburns ___
- ☐ Tanning bed use Y or N

Medications	Drug Allergies	Outdoor Activities

Review of Systems: *Are you experiencing any of the following? (please check all that apply)*

- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Problems with scarring

ALERTS: *(please check all that apply)*

- ☐ Allergy to adhesive
- ☐ Allergy to latex
- ☐ Sensitivity to epinephrine
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotic ointments
- ☐ Artificial heart valve
- ☐ Artificial joints within past two years
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Pacemaker
- ☐ Premedication prior to procedures
- ☐ Rapid heart beat with epinephrine
- ☐ Pregnancy or planning pregnancy