MEDICAL HISTORY FORM

PATIENT NAME: ______________________________________ **TODAY'S DATE**: ______________

PRIMARY CARE PHYSICIAN (NAME): ____

LOCATION: ____

PHARMACY NAME: ____

LOCATION: ____

EMERGENCY CONTACT (Name): ____

PHONE NUMBER: _____________________*RELATIONSHIP TO YOU:* __________________________

DO YOU HAVE A LIVING WILL? ❑ YES ❑ NO

ALLERGIES (List all known allergens)

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DO YOU RECEIVE THE FOLLOWING: Annual Flu Shot? ❑ YES ❑ NO
Pneumonia Vaccine? ❑ YES ❑ NO

MEDICAL HISTORY ~ Select any of the following medical conditions that you currently have.

- ❑ None
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ Bone Marrow Transplant
- ❑ Benign Prostate Hyperplasia
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ Coronary Artery Disease (Heart Disease)
- ❑ Depression
- ❑ Diabetes
- ❑ Renal Disease
- ❑ GERD
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ Hypertension
- ❑ HIV/AIDS
- ❑ High Cholesterol
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke
- ❑ Other ________________________________

SURGICAL HISTORY

Select any of the following surgical procedures that you have had.

- ❑ None
- ❑ Appendix (Appendectomy)
- ❑ Bladder (Cystectomy)
- ❑ Breast: Breast Biopsy
- ❑ Breast: Lumpectomy (*Which breast?* _______________)
- ❑ Breast: Mastectomy (*Which Breast?* ________________)
- ❑ Colon: Colectomy (*Reason?* ______________________)
- ❑ Colon: Colostomy (*Reason?* ______________________)
- ❑ Gallbladder (Cholecystectomy)
- ❑ Heart: Valve Replacement/Repair
- ❑ Heart: Coronary Artery Bypass Surgery
- ❑ Heart: Heart Transplant
- ❑ Heart: Pacemaker
- ❑ Joint Replacement (*Which Joint?* __________________)
- ❑ Kidney: Kidney Biopsy
- ❑ Kidney: Kidney Stone Removal
- ❑ Liver Removal / Hepatectomy
- ❑ Liver Transplant
- ❑ Liver Shunt
- ❑ Ovaries (*Reason:* _______________________)
- ❑ Ovaries: Tubal Ligation
- ❑ Pancreas / Pancreatectomy
- ❑ Prostate Biopsy
- ❑ Prostate Removal (*Reason?* _______________)
- ❑ Rectum
- ❑ Skin Cancer (*Which type?* ________________)
- ❑ Spleen (Splenectomy)
- ❑ Testicles (Orchiectomy)
- ❑ Uterus/Hysterectomy: (*Reason?* ___________)
- ❑ Other __________________________________

SKIN HISTORY

Have you had any of the following skin conditions?

- ❑ None
- ❑ Acne
- ❑ Actinic Keratoses
- ❑ Asthma
- ❑ Basal Cell Skin Cancer
- ❑ Blistering Sunburns
- ❑ Dry Skin
- ❑ Eczema
- ❑ Flaking or Itchy Scalp
- ❑ Hay Fever/Allergies
- ❑ Melanoma
- ❑ Poison Ivy
- ❑ Precancerous Moles
- ❑ Psoriasis
- ❑ Squamous cell skin cancer
- ❑ Other ________________________________

Do you wear Sunscreen? ❑ YES ❑ NO

Do you tan in a tanning salon? ❑ YES ❑ NO

Do you have a family history of Melanoma? ❑ YES ❑ NO If yes, which relative? _____________________

MEDICATIONS

____ ____

____ ____

____ ____

____ ____

SOCIAL HISTORY Check all that apply

- ❑ Current Smoker
- ❑ Former Smoke (What year did you quit? ________)
- ❑ Drink Alcohol (# of drinks per day ________)
- ❑ Street drugs/IV drug use