PATIENT NAME_____ Date_____

Reason for today's visit:_____

PAST MEDICAL HISTORY-(please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
BPH
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
None

OTHER_____

PAST SURGICAL HISTORY--(please circle all that apply)

Appendix Removal
Basal Cell Cancer Surgery
Biological Valve Replacement
Bladder Removal
Breast Biopsy (right/left/bilateral)
Colectomy: Colostomy
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Coronary Artery Bypass
Testicle Removal (right/left/bilateral)
Joint Replacement within last 2 years (right/left/bilateral)
Gallbladder Removal
Heart Transplant
Hysterectomy (cervical cancer)
Hysterectomy Uterine Cancer
Hysterectomy fibroids
Kidney Biopsy
Kidney Removal (right/left
Kidney Stone Removal
Kidney Transplant
Lumpectomy (right/left/bilateral)
Mastectomy (right/left/bilateral)
TURP
Mechanical Valve Replacement
Melanoma Surgery
Ovary Removal (Ovarian cancer)
Ovary Removal (endometriosis/cyst)
Prostate Biopsy/Removal
PTCA
Rectum APR
Skin Biopsy
Spleen Removal
Squamous Cell Carcinoma Surgery
Tubal Ligation
Joint Replacement: KNEE / HIP

OTHER_____

SKIN DISEASE HISTORY

Acne
Actinic Keratosis
Basal Cell Skin Cancer
Blistering Sunburns
Poison Ivy
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
Dry skin

OTHER_____

Do You Wear Sunscreen? YES NO
If yes, What SPF? _____
Do you tan at a tanning salon?
Do you have a Family History of Melanoma? YES NO
If yes, which relatives? _____

PATIENT NAME_____

CAUTIONS: (please circle all that apply)

Have you ever had difficulty stopping bleeding?	YES	NO
Do you require antibiotics prior to surgical procedures?	YES	NO
Have you ever had an artificial joint replacement?	YES	NO
If Yes, what body location and when? _____		
Do you have an artificial heart valve?	YES	NO
Do you have a pace-maker?	YES	NO
Do you have a defibrillator?	YES	NO
Are you pregnant now or trying to become pregnant?	YES	NO

MEDICATIONS: (please enter all current medications)

_____
_____
_____

MEDICATION ALLERGIES: (please enter all allergies to medications)

_____
_____
_____

Height_____ Weight_____

SOCIAL HISTORY: (Please circle all that apply)

*Currently smokes *has smoked in the past *Drug Usage *Exposed to HIV *Alcohol consumption

Other: _____

What is your Occupation? _____

What are your hobbies? _____

RACE: (circle all that apply)

Asian American Indian Caucasian African American Pacific Islander other

ETHNICITY: (circle all that apply)

Non-Hispanic Hispanic Decline

REVIEW OF SYMPTOMS: PLEASE CIRCLE IF YOU ARE EXPERIENCING ANY OF THE FOLLOWING:

Abdominal Pain	Anxiety	Bleeding Problems	Bloody Stool	Wheezing
Bloody Urine	Blurred Vision	Changing Mole	Chest Pains	Thyroid Problems
Cough	Depression	Fever or Chills	Headaches	Sore Throat
Hay Fever	Joint Aces	Muscle Weakness	Neck Stiffness	Seizures
Shortness of Breath	Melanoma History	Unintentional weight loss	Other:	

_____

_____