PATIENT NAME: _____ Date: _____

Reason for today's visit:

_____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Benign Prostatic Hyperplasia
Cerebrovascular accident
Coronary arteriosclerosis
COPD
Depressive disorder
Diabetes
Disease caused by COVID 19
Elevate blood pressure
End Stage Renal
Epilepsy
GERD
Hearing loss
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism/Hypothyroidism
Inflammatory disease of liver
Leukemia
Malignant lymphoma
Malignant tumor of breast
Malignant tumor of colon
Malignant tumor of lung
Malignant tumor of prostate
Radiation therapy treatment mgmt
Transplantation of bone marrow
None

Other: _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Basal Cell Cancer Surgery
Biopsy of breast
Biopsy of prostate
Coronary Artery Bypass
Entire transplanted Kidney
H/O: colostomy
H/O: tubal ligation
H/O: appendectomy
H/O: cholecystectomy
History of liver excision
Heart Transplant
Hysterectomy
History of total cystectomy
H/O transurethral prostatectomy
Kidney biopsy
History of total cystectomy
Low anterior resection of rectum
Lumpectomy (right/left/bilateral)
Mastectomy (right/left/bilateral)
Mechanic Valve Replacement
Melanoma Surgery
Oophorectomy
Pancreatectomy
Portosystemic shunt operation
Prostatectomy
Splenectomy
Squamous Cell Carcinoma Surgery
Total nephrectomy/Total orchidectomy
Transplant of Heart
Transplant of Liver
Joint Replacement: Knee / Hip (right/left/bilateral)

Dates _____

Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratosis
Asteatosis cutis
Basal Cell Skin Cancer
Contact dermatitis / Poison Ivy
Dysplastic Nevus of skin
Eczema
H/O asthma
H/O hay fever
None
Malignant Melanoma
Pruritis of scalp
Psoriasis
Squamous Cell Carcinoma
Sunburn of second degree

Other: _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan at a tanning salon? Yes No
Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____

PATIENT NAME_____

Cautions: (please circle all that apply)

Have you ever had difficulty stopping bleeding? Yes No
Do you require antibiotics prior to surgical procedure? Yes No
Have you ever had an artificial joint replacement? Yes No
If yes when and what body location? _____
Do you have an artificial heart valve? Yes No
Do you have a pacemaker? Yes No
Do you have a defibrillator? Yes No
Are you pregnant or currently trying to get pregnant? Yes No

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____

Height_____ Weight_____

Social History: (Please circle all that apply)

Currently smokes / has smoked in the past / Drug Use / Exposed to HIV/Other: _____

Alcohol: Less than 1 / 1-2 drinks per day / 3 or more per day

MALE ADULTS OLDER THAN 65: How many times in the past year have you had 5 or more drinks in one day
FEMALE ADULTS OLDER THAN 65: How many times in the past year have you had 4 or more drinks in one day

What is your occupation? _____

What are your hobbies? _____
_____

Race: Asian / American Indian / Caucasian / African American / Pacific Islander / other_____

Ethnicity: Non-Hispanic / Hispanic / Decline

Review of Systems: 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 Aches	Muscle Weakness	Neck Stiffness	Seizures
Shortness of Breath	Unintentional Weight Loss			
Melanoma History	Other:			

_____