MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____

Reason for today's visit: _____

CURRENT MEDICATIONS TAKING (prescriptions, over-the-counter meds, vitamins, herbal treatments) *Use back of form if needed*

Name	Strength	Route	Dose	Frequency	Name	Strength	Route	Dose	Frequency

DO YOU HAVE, OR HAD ANY OF THE FOLLOWING CONDITIONS? *Check only those that apply & write Location/Date*

Past Medical History — *Area/Year*

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation _____
- ❑ Bone Marrow Transplantation _____
- ❑ BPH (prostate enlargement) _____
- ❑ Breast Cancer _____
- ❑ Colon Cancer _____
- ❑ Chronic Obstructive Pulmonary disease
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD (acid reflux, heartburn)
- ❑ Hearing Loss
- ❑ Hepatitis _____
- ❑ Hypertension
- ❑ HIV/AIDS _____
- ❑ Hypercholesterolemia _____
- ❑ Hyperthyroidism _____
- ❑ Hypothyroidism _____
- ❑ Leukemia _____
- ❑ Lung Cancer _____
- ❑ Lymphoma _____
- ❑ Prostate Cancer _____
- ❑ Radiation Treatment _____
- ❑ Seizures _____
- ❑ Stroke _____
- ❑ OTHER: _____

Skin Disease History

- ❑ Acne
- ❑ Actinic Keratoses
- ❑ Asthma
- ❑ Basal Cell Skin Cancer _____
- ❑ Blistering Sunburn (s)
- ❑ Dry Skin
- ❑ Eczema
- ❑ Flaking or Itchy Scalp
- ❑ Hay Fever/Allergies
- ❑ Melanoma _____
- ❑ Poison Ivy _____
- ❑ Precancerous Moles _____
- ❑ Psoriasis _____
- ❑ Squamous Cell Skin Cancer _____
- ❑ OTHER: _____

Medical conditions or recent surgery
(within last 6 months):

_____
_____
_____
_____

Past Surgical History — *Area/Year*

- ❑ Appendix Removed _____
- ❑ Bladder Removed _____
- ❑ Breast Biopsy (Right, Left, Both) _____
- ❑ Lumpectomy (R, L, B) _____
- ❑ Mastectomy (R, L, B) _____
- ❑ Colon Cancer Resection _____
- ❑ Colectomy: Diverticulitis
- ❑ Inflammatory Bowel Disease _____
- ❑ Gallbladder Removed _____
- ❑ Biological Valve Replacement _____
- ❑ Coronary Artery Bypass Surgery _____
- ❑ Heart transplant _____
- ❑ Mechanical Valve Replacement _____
- ❑ Heart: PTCA _____
- ❑ Hip Joint Replacement (R, L, B) _____
- ❑ Knee Joint Replacement (R,L,B) _____
- ❑ Kidney Biopsy
- ❑ Kidney Transplant _____
- ❑ Kidney: Nephrectomy _____
- ❑ Liver: Hepatectomy _____
- ❑ Liver Transplant _____
- ❑ Liver Shunt _____
- ❑ Ovaries Removed _____
- ❑ Ovarian Cancer Removed _____
- ❑ Ovarian Cyst Removed _____
- ❑ Tubal Ligation _____
- ❑ Pancreas: Pancreatectomy _____
- ❑ Prostate Biopsy
- ❑ Prostate Cancer _____
- ❑ Prostate: TURP _____
- ❑ Rectum: APR _____
- ❑ Skin: Basal Cell _____
- ❑ Skin: Melanoma _____
- ❑ Skin Biopsy _____
- ❑ Skin: Squamous Cell _____
- ❑ Spleen Removal _____
- ❑ Testicles Removal _____
- ❑ Hysterectomy: Fibroids _____
- ❑ Hysterectomy Uterine Cancer _____
- ❑ Hysterectomy Cervical Cancer _____
- ❑ OTHER: _____

Current Influenza Immunization: ❑Yes ❑No
We recommend yearly immunization

Vaccinated for Pneumonia: ❑Yes ❑No

Do you wear sunscreen? ❑ Yes: SPF___ ❑No

Do you go to a tanning salon? ❑ Yes ❑ No

Are you pregnant? ❑Yes:_____ ❑No ❑Maybe
Due date

Review of Systems (current symptoms)

- ❑ Fever or chills
- ❑ Unintentional weight loss
- ❑ Night sweats
- ❑ Immunosuppression (low immune system)
- ❑ Enlarged lymph nodes
- ❑ Problem with bleeding
- ❑ Problem with healing
- ❑ Problem with scarring (keloids)
- ❑ Rash
- ❑ New or Changing mole
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Cough
- ❑ Wheezing
- ❑ Sore throat
- ❑ Blurry Vision
- ❑ Thyroid problems
- ❑ Abdominal pain
- ❑ Bloody stool
- ❑ Bloody urine
- ❑ Joint aches
- ❑ Muscle weakness
- ❑ Neck stiffness
- ❑ Headaches
- ❑ Seizures
- ❑ Anxiety
- ❑ Depression

ALERTS

- ❑ Pacemaker
- ❑ Defibrillator
- ❑ Premedication before procedures
- ❑ Artificial heart valve
- ❑ Artificial joints within the past 6 months
- ❑ Allergy to lidocaine (Xylocaine)
- ❑ Rapid heartbeat with epinephrine
- ❑ Allergy to adhesive/tape
- ❑ Allergy to topical antibiotic ointments
- ❑ Blood thinners
- ❑ MRSA (staph infection)
- ❑ Pregnancy or planning pregnancy
- ❑ Hospice
- ❑ OTHER: _____

Do you know any "blood relative" who has/had melanoma? ❑ Yes ❑ No
Type & whom? _____
_____

Allergies: ❑ NONE (or list all Allergies)
_____
_____
_____

Patient Signature/POA/Guardian: _____ **Name:** _____ **Date:** _____
Form Completed by: ❑ **Patient** ❑ **Nurse/MA - Initials:**