Name: ____________________________ Date: ___________________________
Date of Birth: ______________________

MEDICAL INFORMATION
PLEASE COMPLETE ALL 3 PAGES

Reason for visit: ____
____

PAST MEDICAL HISTORY (Please circle all that apply)

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

PAST SURGICAL HISTORY (Please circle all that apply)

- Appendectomy
- Bladder Surgery
- Breast Surgery
  - Mastectomy
  - Lumpectomy
  - Reduction
  - Implants
- Colon Surgery
  - Cancer Resection
  - Diverticulitis
  - Inflammatory Bowel Disease
- Gall Bladder Removal
- Heart Surgery
  - Bypass
  - Angioplasty
  - Valve Replacement
  - Transplant
- Joint Replacement
  - Hip, Right
  - Hip, Left
  - Knee, Right
  - Knee, Left
- Kidney Surgery
  - Biopsy
  - Nephrectomy
  - Stone Removal
  - Transplant
- Ovarian Surgery
  - Endometriosis
  - Ovarian Cyst
  - Ovarian Cancer
- Prostate Surgery
  - Cancer
  - Biopsy
  - TURP

CONTINUE →

MEDICAL INFORMATION

PAST SURGICAL HISTORY (cont.)

- Skin Surgery
  - Biopsy
  - Basal Cell Carcinoma
  - Squamous Cell Carcinoma
  - Malignant Melanoma
- Other ___________________________
- None
- Spleen Surgery
- Testicular Surgery
- Uterine Surgery/Hysterectomy
  - Fibroids
  - Cancer

SKIN DISEASE HISTORY (Please circle all that apply)

- Acne
- Actinic Kerastosis
- Asthma
- Basal Cell Carcinoma
- Blistering Sunburns
- Dry Skin
- Eczema
- Other_________________________
- None
- Flaking or Itchy Skin
- Hay Fever/Allergies
- Malignant Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Carcinoma

DO YOU WEAR SUNSCREEN? _______________

If yes, what level SPF? __________________

DO YOU TAN IN A TANNING SALON? ________________

FAMILY HISTORY

Do you have a family history of Melanoma? _______________

If yes, which relative(s)? ____

MEDICATIONS (Please List All Medications Below)

DRUG ALLERGIES (Please List All Medication Allergies Below)

PHARMACY NAME: ____

PHARMACY PHONE NUMBER: ____

CONTINUE →

SOCIAL HISTORY

Alcohol Use? Yes or No
Drug Use? Yes or No
Smoking Status
- Current Smoker
- Former Smoker
- Never Smoker

How often do you Exercise
- Daily
- Weekly
- Monthly
- Never

Caffeine use?
- Daily
- Weekly
- Monthly
- None

Pregnancy Status
- Currently pregnant
- Planning to become pregnant
- Not pregnant

OCCUPATION: ____

REVIEW OF SYSTEMS (Please circle all that apply)
- Problems with bleeding
- Problems with healing
- Rash
- Immunosuppression
- Chest Pain
- Fever or Chills
- Joint Aches
- Problems with scarring (hypertrophic or keloid)
- None
- Headaches
- Cough
- Shortness of Breath
- Anxiety
- Depression
- Decrease in night vision

ALERTS (Please circle all that apply)
- Allergy to adhesive
- Allergy to lidocaine
- Allergy to topical antibiotic ointments
- Artificial joints within past 2 years
- Defibrillator
- Rapid heartbeat with epinephrine
- None
- MRSA
- Pacemaker
- Artificial heart valve
- Blood thinners
- Premedication prior to procedures