

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_ / \_\_\_ / \_\_\_ **Date:** \_\_\_ / \_\_\_ / \_\_\_

**Marital status:** Married/Single/Divorced/Widowed/Separated/Common Law/ Domestic Partner/unknown

**Preferred Language:** \_\_\_\_\_ **Race:** \_\_\_\_\_ (ex. White/African American/Asian)

**Ethnic Group:**  Hispanic or Latino  Not Hispanic or Latino  Unknown  I choose not to specify

**Pharmacy (name/town/phone #):** \_\_\_\_\_

**Referring/Primary Care Dr.** \_\_\_\_\_ **Last Visit Date** \_\_\_\_\_

**Past Medical History:** (please circle all that apply)

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"><li>• Anxiety</li><li>• Arthritis</li><li>• Asthma</li><li>• Atrial fibrillation</li><li>• Bone marrow transplant</li><li>• BPH</li><li>• Breast cancer</li><li>• Colon cancer</li><li>• COPD</li><li>• Coronary artery disease</li></ul> | <ul style="list-style-type: none"><li>• Depression</li><li>• Diabetes</li><li>• End stage renal disease</li><li>• GERD</li><li>• Head trauma</li><li>• Hearing loss</li><li>• Hepatitis</li><li>• Hypertension</li><li>• HIV / AIDS</li><li>• Hypercholesterolemia</li></ul> | <ul style="list-style-type: none"><li>• Hyperthyroidism</li><li>• Hypothyroidism</li><li>• Leukemia</li><li>• Lung cancer</li><li>• Lymphoma</li><li>• Prostate cancer</li><li>• Radiation treatment</li><li>• Seizures</li><li>• Stroke</li></ul> |
|---|--|--|

**Other:** \_\_\_\_\_

**Past Surgical History:** (Please List all previous surgeries)

**Family History:** (please circle all that apply)

- |                            |   |
|----------------------------|---|
| • Melanoma                 | Mom – Dad – Sister – Brother – Daughter – Son |
| • Non-Melanoma Skin Cancer | Mom – Dad – Sister – Brother – Daughter – Son |
| • Diabetes                 | Mom – Dad – Sister – Brother – Daughter – Son |
| • High-Cholesterol         | Mom – Dad – Sister – Brother – Daughter – Son |
| • High Blood Pressure      | Mom – Dad – Sister – Brother – Daughter – Son |

Additional Family History: \_\_\_\_\_

**Skin Disease History:** (please circle all that apply)

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"><li>• Acne</li><li>• Actinic keratosis</li><li>• Asthma</li><li>• Basal cell skin cancer</li><li>• Blistering sunburns</li></ul> | <ul style="list-style-type: none"><li>• Dry skin</li><li>• Eczema</li><li>• Flaking/itchy scalp</li><li>• Hay fever/allergies</li><li>• Melanoma</li></ul> | <ul style="list-style-type: none"><li>• Poison Ivy</li><li>• Precancerous moles</li><li>• Psoriasis</li><li>• Squamous cell skin cancer</li></ul> |
|--|--|---|

**Other:** \_\_\_\_\_

**DO YOU WEAR SUNSCREEN? (YES/NO) what SPF:** \_\_\_\_\_

**DO YOU TAN IN A TANNING SALON? (YES/NO)**

**\*Turn over to complete form\***

**REVIEW OF SYSTEMS:** Are you currently experiencing any of the following? (Please check yes or no)

Symptom	Yes	No
Are you in generally good health?		
Do you have problems with bleeding?		
Do you have problems with healing?		
Do you have problems with scarring?		
Do you currently have a rash?		
Do you have any new skin lesions?		
Do you have any changing skin lesions?		

**MEDICATIONS/VITAMINS** (please provide current list of medications):  NO MEDICATIONS

Name: \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Name: \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Name: \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Name: \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Name: \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency: \_\_\_\_\_

**DRUG ALLERGIES** (please list all known allergies and reactions):  NO KNOWN DRUG ALLERGIES

\_\_\_\_\_  
 \_\_\_\_\_

**SOCIAL HISTORY:**

**Smoking status:**  Current every day smoker  Current someday smoker  Former smoker  Never smoker

**Alcohol Use:**  None  <1 drink per day  1-2 drinks per day  3 or more drinks per day

**Occupation:** \_\_\_\_\_

**ALERTS:** (please circle all that apply)

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Allergy to adhesive</li> <li>• Allergy to latex</li> <li>• Allergy to lidocaine</li> <li>• Artificial valve replacement</li> </ul> | <ul style="list-style-type: none"> <li>• Artificial joint replacement</li> <li>• Blood thinners</li> <li>• Defibrillator</li> <li>• Keloid scarring</li> </ul> | <ul style="list-style-type: none"> <li>• MRSA</li> <li>• Pacemaker</li> <li>• Require antibiotics prior to procedure</li> <li>• Rapid heartbeat with epinephrine</li> </ul> |
|---|--|---|

**ARE YOU PREGNANT OR CURRENTLY TRYING TO GET PREGNANT?**  YES  NO

- 1) Did you receive the flu vaccination this flu season? **(YES/NO)**
- 2) Are you 65 or older and have received the pneumonia vaccine? **(YES/NO)**
- 3) Do you have Advance Care Plan? **( YES/NO)**

**AND/OR** Who is your surrogate medical decision maker :

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

- 4) Do you have any of the following conditions: ( Please circle)

Coronary Artery Disease ( Heart Disease)

Congestive Heart Failure

Diabetes

Chronic Obstructive Lung Disease( Chronic Bronchitis/ Emphysema)