Medical History Form Appointment Date: _____

Mr. /Mrs. /Ms. /Dr. (Circle One)

Last Name: _____First Name: _____MI: _____

Date of Birth: (MM/DD/YYYY) _____ Sex: M / F **(Circle)** Occupation: _____

Marital Status: **(Circle One)** Married Single Divorced Widowed Other: _____

Preferred Pharmacy: _____Cross Streets: _____

Yes, No Do you have a separate card for prescription benefits?
If Yes, Please give the benefits card to the patient service representative when you check-in.

Reason(s) for today's visit: _____

Primary Care Provider: _____ Referring Provider: _____

Please write in an answer or circle yes or no to all the questions below.

Past Medical History:

Have you been previously diagnosed with any of the following? **(Circle all that apply or circle none.)**

Anxiety
Arthritis
Asthma
Atrial Fibrillation/Irregular Heartbeat
Benign Prostatic Hyperplasia
Bone Marrow Transplant
Breast Cancer
Bleeding Problems
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End-Stage Renal Failure
Gastro Reflux Disease
Hearing Loss
Hepatitis
High Blood Pressure
HIV/Aids
High Cholesterol
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
NONE

List any other diseases or conditions: _____

List any surgical procedures you have had in the last **24** months:

_____

Yes, No Have you ever received a flu vaccine?
Yes, No Have you ever received a pneumonia vaccine?
Yes, No Do you have and Advance Care Plan? If **YES**, please list the person's name and contact number below.

Name: _____ Contact Number: _____

_____

Skin Disease History: (Circle all that apply or circle none.)

Acne
Actinic Keratosis/Precancerous Lesions
Atypical Moles (**Only** if diagnosed by a physician)
Basal Cell Carcinoma/Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Melanoma
Psoriasis
Squamous Cell Carcinoma/Skin Cancer
NONE
Other: _____

Appointment Date: _____

Last Name: _____ First Name: _____MI: _____

Date of Birth: (MM/DD/YY):_____

_____

Yes **No** Do you wear sunscreen? **If so, what SPF?** _____

Yes, **No** Are you currently using a tanning bed?

Family Medical History:

Yes **No** Do you have a family history of MELANOMA?

If yes, which relatives? **(Circle all that apply.)**

Mother Father Sister Brother Daughter Son Grandmother Grandfather Nephew Niece Other

Medications:

List all medications you are currently taking. Include prescriptions over the counter medications, vitamins, and herbals. Use additional paper if needed. Please notify our office if you decline to have your medication list imported from participating pharmacies. **PLEASE GIVE YOUR PHARMACY INSURANCE CARD TO THE FRONT OFFICE AT CHECK IN TO HELP FACILITATE YOUR MEDICATIONS ARE AUTHORIZED PROPERLY.**

NAME	STRENGTH/AMOUNT	DOSE (Tablet, Capsule, etc.)	FREQUENCY

Allergies:

Yes **No** Are you allergic to any medications?

If **yes**, list all medications: _____

Social History:

Yes **No** Are you a current smoker? Cigarette Smoker / Cigar Smoker / Both **(Circle one.)**

Total Years Smoking: _____ If yes, how many packs per day? _____

Yes No Are you a former smoker?

Total Years Smoked: _____ If yes, how many packs did you smoke per day?

_____

Yes No Not Sure Do you develop Keloid (raised) scars after surgery?

Yes **No** **Not Sure** Do you bleed easily?

Have you had previous problems with any of the following? (Circle all that apply or circle none.)

Allergic Reaction to Adhesive Bandages
Allergic Reaction to Topical Antibiotic Ointments
Artificial Heart Valve
Artificial Joints within the Last 2 Years
Blood Thinners
OTHER:_____

Defibrillator
MRSA
Pacemaker
Premedication Before Procedures
Rapid Heartbeat with Epinephrine/Local Anesthesia
NONE

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