MEDICAL HISTORY

Name: _____ **Date of Birth**: _____**Today's Date:**_____

Reason for Visit: _____

Past Medical History: (please check all that apply)

__ Anxiety
__ Arthritis
__ Asthma
__ Blood Clots
__ Cancer, Type _____
__ Crohn's disease/Ulcerative Colitis
__ Depression
__ Diabetes
__ End Stage Renal Disease (kidney disease)
__ Fainting
__ Hepatitis, Type _____
__ Hypertension (High blood pressure)
__ HIV/AIDS
__ Hypercholesterolemia (High cholesterol)
__ Hyperthyroidism (Over active thyroid)
__ Hypothyroidism (Under active thyroid)
__ Pacemaker/Defibrillator
__ Radiation Treatment
__ Valve Replacement

Other Medical History

_____
_____

Past Surgical History: (please check all that apply)

__ Mechanical Valve Replacement
__ Biological Valve Replacement
__ Organ Transplant, Type _____
__ Joint Replacement, Type_____

Other Past Surgical History

_____
_____

Skin Disease History: (please check all that apply)

__ Acne
__ Actinic Keratoses
__ Basal Cell Skin Cancer
__ Dry Skin
__ Eczema
__ Flaking or Itchy Scalp
__ Hay Fever/Allergies
__ Melanoma
__ Mohs Surgery
__ Psoriasis
__ Squamous Cell Skin Cancer

Other Skin Disease History

_____
_____

Medical Questions Continued: (please circle)

Do you wear Sunscreen? Yes No If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Family history of Melanoma: Yes No If yes, which relative(s)? _____

Social History: (please circle)

Cigarette Smoking?	Never smoked		Quit: former smoker	Smokes less than daily	Smokes daily
Alcohol Use?	Yes	No			
Are you pregnant or nursing?	Yes	No			

Review of Systems: **Do you <u>currently</u> have any problems with the following?** (please check all that apply)

__ Bleeding
__ Healing
__ Scarring
__ Rash
__ Immunosuppression
__ Fever or chills
__ Night sweats
__ Unintentional weight loss
__ Thyroid problems
__ Abdominal pain
__ Joint aches
__ Muscle weakness
__ Anxiety
__ Depression

Vaccination Status: (please circle)

For patients 65 and older, have you received a pneumonia vaccination? Yes No

Advance Care:

For patients 65 and older, do you have a healthcare proxy in the event you are unable to make your own medical decisions?

Yes No

If Yes, Designee's name: _____

Designee's phone number: _____-_____-_____

Pharmacy (all patients):

Name: _____

Mailing Address: _____

City _____ State _____ Zip _____

Phone: _____-_____-_____