MEDICAL HISTORY

Name: ______________________________ **Date of Birth**: ____________________**Today's Date:**_________________________

Reason for Visit: ____

Past Medical History: (please check all that apply)

__ Anxiety
__ Arthritis
__ Artificial joints
__ Asthma
__ Atrial fibrillation
__ BPH (Benign Prostatic Hyperplasia)
__ Blood Clots
__ Bone Marrow Transplantation
__ Breast Cancer, Diagnosis Date _____
__ Colon Cancer, Diagnosis Date _____
__ COPD (Emphysema)
__ Coronary Artery Disease
__ Depression
__ Crohn's
__ Diabetes
__ End Stage Renal Disease
__ Fainting
__ GERD (Acid reflux)
__ Hearing Loss
__ Heart Attack
__ Hepatitis, Type _____
__ Hypertension (High blood pressure)
__ HIV/AIDS
__ Hypercholesterolemia
(High cholesterol)
__ Hyperthyroidism (Over active thyroid)
__ Hypothyroidism (Under active thyroid)
__ Irritable Bowel Syndrome
__ Leukemia
__ Lung Cancer, Diagnosis Date _____
__ Lymphoma
__ Pacemaker
__ Prostate Cancer, Diagnosis Date _____
__ Radiation Treatment
__ Seizures
__ Stroke
__ Valve Replacement
__ None

Other

____
____

Past Surgical History: (please check all that apply)

__ Appendix Removed
__ Bladder Removed
__ Mastectomy (Right, Left, Bilateral)
__ Lumpectomy (Right, Left, Bilateral)
__ Breast Biopsy (Right, Left, Bilateral)
__ Breast Reduction
__ Breast Implants
__ Colectomy: Colon Cancer Resection
__ Colectomy: Diverticulitis
__ Colectomy: IBD
__ Gallbladder Removed
__ Coronary Artery Bypass
__ PTCA
__ Mechanical Valve Replacement
__ Biological Valve Replacement
__ Heart Transplant
__ Joint Replacement, Knee
(Right, Left, Bilateral)
__ Joint Replacement, Hip
(Right, Left, Bilateral)
__ Joint Replacement within last 2 years
__ Kidney Biopsy
__ Kidney Removed (Right, Left)
__ Kidney Stone Removal
__ Kidney Transplant
__ Ovaries Removed: Endometriosis
__ Ovaries Removed: Cyst
__ Ovaries Removed: Ovarian Cancer
__ Prostate Removed: Prostate Cancer
__ Prostate Biopsy
__ TURP
__ Skin Biopsy
__ Basal Cell Cancer Surgery
__ Squamous Cell Carcinoma Surgery
__ Melanoma Surgery
__ Spleen Removed
__ Testicles Removed
(Right, Left, Bilateral)
__ Hysterectomy: Fibroids
__ Hysterectomy: Uterine Cancer
__ None

Other

____
____

Skin Disease History: (please check all that apply)

__ Acne
__ Actinic Keratoses
__ Basal Cell Skin Cancer
__ Blistering Sunburns
__ Dry Skin
__ Eczema
__ Flaking or Itchy Scalp
__ Hay Fever/Allergies
__ Melanoma
__ Mohs Surgery
__ Poison Ivy
__ Precancerous Moles
__ Psoriasis
__ Squamous Cell Skin Cancer
__ None

Other

____
____

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		
Do you bleed easily?	Yes	No		

Review of Systems: **Do you have any problems with the following?** (Please circle)

Bleeding	Yes	No	Abdominal pain	Yes	No
Healing	Yes	No	Bloody stool	Yes	No
Scarring	Yes	No	Bloody urine	Yes	No
Rash	Yes	No	Joint aches	Yes	No
Immunosuppression	Yes	No	Muscle weakness	Yes	No
Hay fever	Yes	No	Neck stiffness	Yes	No
Chest pain	Yes	No	Headaches	Yes	No
Fever or chills	Yes	No	Seizures	Yes	No
Night sweats	Yes	No	Cough	Yes	No
Unintentional weight loss	Yes	No	Shortness of breath	Yes	No
Thyroid problems	Yes	No	Wheezing	Yes	No
Sore throat	Yes	No	Anxiety	Yes	No
Blurry vision	Yes	No	Depression	Yes	No

Pharmacy:

Name: ____

Mailing Address: _______________________________________

City ________________________ State _________ Zip _____________

Phone: _________-_________-_____________

Rev. 9-9-18