Patient Name:	MR#:
Appointment Date:	Page 1
Chief Complaint: (Please write reason, symptoms, condition or diagnosis that prompts your appointment)	

Past Medical History

RELEVANT MEDICAL HISTORY		DETAILS
Artificial Joints/Implants	☐	
Asthma	☐	
Blood Clots/ Bleeding Disorder	☐	
Breast Cancer	☐	
Chest Pain	☐	
Chemical/ Radiation Therapy	☐	
Defibrillator	☐	
Diabetes	☐	
Eye Problems	☐	
Heart Disease	☐	
Heart Murmur	☐	
Hepatitis	☐	
High Blood Pressure	☐	
Liver Disease	☐	
Malignant Hyperthermia	☐	
MRSA	☐	
Neurologic Disease	☐	
Pacemaker	☐	
Psychiatric Condition	☐	
Radiation Therapy/Chemotherapy	☐	
Stroke	☐	
Thyroid Disorder	☐	
Non-relevant medical history	☐	
Other relevant medical history	☐	

SKIN HISTORY		Previous Treatments	Location	Notes
None	☐			
Acne	☐			
Dry Skin	☐			
Eczema	☐			
Hives or Itching	☐			
Infection of the skin	☐			
Keratosis	☐			
Melanoma	☐			
Moles	☐			
Psoriasis	☐			
Rashes	☐			
Scars	☐			
Skin Cancer	☐			

Patient Name:	MR#:
Appointment Date:	Page 2

SKIN HISTORY (Continued)		Previous Treatments	Location	Notes
Sores – Cold, Bed, etc.	☐			
Sun Exposures	☐			
Suspicious Lesion	☐			
Ulcers	☐			
Warts	☐			

PAST SURGERIES/HOSPITALIZATIONS

Surgery Type	Surgery/Hospitalization	Year	Anesthesia Complications	Notes

FAMILY HISTORY

		Afflicted Family Member	Notes
Allergies	☐		
Autoimmune Disorders	☐		
Breast Cancer	☐		
BRCA Positive	☐		
Diabetes	☐		
Heart Disease	☐		
High Blood Pressure	☐		
Hemophilia	☐		
Obesity	☐		
Other Cancer	☐		
Melanoma	☐		
Metabolic Disease	☐		
Sinusitis	☐		
Skin Cancer Other	☐		
Non-relevant family history	☐		
Unknown (Adopted)	☐		
Other relevant family history	☐		
*Females Only	☐		
Do you take birth control?	☐		
Are you pregnant?	☐		
Are you breast feeding?	☐		
Do you plan on becoming pregnant?	☐		

Preferred Pharmacy Name and Address:	

SOCIAL HISTORY

Do you live alone?	□ Yes □ No
Do you use recreational drugs?	□ Yes □ No
Have you used a tanning bed?	□ Yes □ No

Do you drink alcohol?	□ Yes □ No		
MEN ONLY	How many times in the past year have you had more than 4 drinks in a day?		
WOMEN ONLY	How many times in the past year have you had more than 3 drinks in a day?		
Smoking Status:	□ Never smoker	□ Current every day smoker	□ Current some days smoker
□ Former smoker	□ Heavy tobacco user	□ Light tobacco user	
□ Unknown if ever smoked	□ Smoker, current status unknown		
Started Date:	Ended Date:		

	YES	
Have you had the flu shot within the last year? (If yes, select an option below)	□	
Influenza immunization previously received at home (home health or pharmacy).	□	Date:
Influenza immunization previously received at work.	□	Date:
Influenza immunization was not administered, reason not given.	□	
If you're 65 or older; have you ever received a pneumonia vaccine? If Yes, date:	□	Date:

Do you take these medications daily?

□ Aspirin □ Advil □ Motrin □ Aleve □ Celebrex □ Coumadin □ Plavix □ Xarelto □ Pradaxa □ Warfarin

□ Any non-listed blood thinner?

Please list any other medications you are taking	**Please list any drug allergies you may have**
MEDICATIONS	**ALLERGIES**

Review of Systems

Are you currently experiencing any of the following symptoms?

SKIN	YES	NO	Yes - Details
Rash	□	□	
Sores	□	□	
New or changing lesions	□	□	
Itching/burning	□	□	
CONSTITUTIONAL	YES	NO	Yes - Details
Fever	□	□	
Chills	□	□	
Fatigue	□	□	
Weight loss	□	□	