Name:_____Reason for Visit:_____

Date of Birth:_____Primary Care Physician: _____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ None
- ☐ Other _____

_____

_____

_____

_____

_____

_____

Past Surgical History

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Liver: Liver Transplant
- ☐ Other _____

_____

_____

_____

- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy: Prostate Cancer
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ None

Prescription History consent

(This will allow us access to your prescription history)

Please check one:

☐ Yes ☐ No

*Name:*_____

Medications

List all current medications:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies

List all allergies and reactions if known:

_____
_____

Preferred Pharmacy

Name: _____

City, Zip code: _____

Phone: _____

Vaccination Status

Have you had any of the following?

Pneumonia Vaccine

☐Yes ☐ No

Flu Vaccine

☐Yes ☐ No

Advanced Care

Do you have a health care proxy in the event you are unable to make your own medical decisions?

Please check one:

☐Yes ☐No

Name:_____

Phone number:_____

Skin History

Have you had any of the following?

- ☐Acne
- ☐Actinic Keratoses
- ☐Basal Cell Skin Cancer
- ☐Blistering Sunburns
- ☐Eczema
- ☐Hay Fever / Allergies
- ☐Melanoma
- ☐Precancerous Moles
- ☐Psoriasis
- ☐Squamous Cell Skin Cancer
- ☐None
- ☐Other _____

Do you wear Sunscreen?

☐Yes ☐No

Do you tan in a tanning salon?

☐Yes ☐No

Do you have a family history of Melanoma?

☐Yes ☐No

If yes, which relative?

- ☐Mother
- ☐Father
- ☐Sister
- ☐Brother
- ☐Daughter
- ☐Son
- ☐Grandmother
- ☐Grandfather
- ☐ Other _____

Social History

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 2 or more per day

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Former smoker
- ☐ Never a smoker