

Patient Name: _____ DOB: ____ / ____ / ____
FIRST M.I. LAST

Smoking Status: Current smoker Former smoker Never smoker Preferred Language: _____

Race: _____ Ethnic Group: Hispanic or Latino Not Hispanic or Latino Unknown I choose not to specify

Pharmacy: _____
NAME TOWN PHONE NUMBER

Primary Care Provider: _____

PAST MEDICAL HISTORY: (please check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> End stage renal disease | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> GERD | <input type="checkbox"/> Lung cancer |
| <input type="checkbox"/> Bone marrow transplant | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> BPH | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prostate cancer |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Colon cancer | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Coronary artery disease | | |

OTHER:

PAST SURGICAL HISTORY: (please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Appendix removed | <input type="checkbox"/> Kidney biopsy |
| <input type="checkbox"/> Bladder removed | <input type="checkbox"/> Kidney stone removal |
| <input type="checkbox"/> Breast biopsy | <input type="checkbox"/> Kidney transplant |
| <input type="checkbox"/> Lumpectomy: <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> bilateral | <input type="checkbox"/> Kidney removed |
| <input type="checkbox"/> Mastectomy: <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> bilateral | <input type="checkbox"/> Hepatectomy |
| <input type="checkbox"/> Colectomy: <input type="checkbox"/> colon cancer <input type="checkbox"/> diverticulitis | <input type="checkbox"/> Liver transplant |
| <input type="checkbox"/> Colostomy | <input type="checkbox"/> Liver shunt |
| <input type="checkbox"/> Gallbladder removed | <input type="checkbox"/> Ovaries removed: <input type="checkbox"/> endometriosis <input type="checkbox"/> cancer <input type="checkbox"/> cyst |
| <input type="checkbox"/> Biological valve replacement | <input type="checkbox"/> Pancreas removed |
| <input type="checkbox"/> Coronary artery bypass | <input type="checkbox"/> Prostate removed: <input type="checkbox"/> cancer <input type="checkbox"/> TURP |
| <input type="checkbox"/> Heart transplant | <input type="checkbox"/> Rectal resection |
| <input type="checkbox"/> Mechanical valve replacement | <input type="checkbox"/> Spleen removed |
| <input type="checkbox"/> Angioplasty (PTCA) | <input type="checkbox"/> Testicles removed: <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> bilateral |
| <input type="checkbox"/> Hip replacement: <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> bilateral | <input type="checkbox"/> Hysterectomy: <input type="checkbox"/> fibroids |
| <input type="checkbox"/> Knee replacement: <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> bilateral | <input type="checkbox"/> Hysterectomy: <input type="checkbox"/> uterine cancer <input type="checkbox"/> cervical cancer |

OTHER:

SKIN DISEASE HISTORY: (please check all that apply)

DO YOU HAVE A FAMILY HISTORY OF MELANOMA? YES NO If yes, which relative(s)?:

- | | | |
|---|--|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Poison ivy |
| <input type="checkbox"/> Actinic keratosis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Precancerous moles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Flaking/itchy scalp | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Basal cell skin cancer | <input type="checkbox"/> Hay fever/allergies | <input type="checkbox"/> Squamous cell skin cancer |
| <input type="checkbox"/> Blistering sunburns | <input type="checkbox"/> Melanoma | |

OTHER:

MEDICATIONS

DRUG ALLERGIES

ALERTS: (please check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Blood thinners | <input type="checkbox"/> Premedication prior to procedures |
| <input type="checkbox"/> Allergy to lidocaine | <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Rapid heart beat with epinephrine |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> MRSA | <input type="checkbox"/> Currently pregnant |
| <input type="checkbox"/> Allergy to adhesive | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Planning pregnancy |

What is the reason for your visit today?