Patient Name______________________________ **Patient DOB:** ____/____/_____ **Gender**______

Address: ____ Phone :___________

(Street) (City) (State) (Zip code)

Email____

Race: White___, American Indian___, Asian___, African American___, Native ______, other race___

Ethnicity: Hispanic/Latin, Not Hispanic/Latin, Unknown **Preferred Language:** ________________

Patient employer: ________________ Address ____

How did you hear about our office? ____

Primary Care Physician: ____

Reason for your visit: ___________________________ How long have you had this problem? __________

How severe is the condition that affects you? (please circle) **mild moderate severe**

Past Medical History:

__ Hepatitis
__ Artificial joints
__ Asthma
__ Atrial fibrillation
__ BPH (Benign Prostatic Hyperplasia)
__ Bone Marrow Transplantation
__ Breast Cancer
__ Colon Cancer
__ COPD
__ Coronary Artery Disease
__ Depression
__ Diabetes
__ End Stage Renal Disease
__ GERD
__ Hearing loss
___Other________________________
__Anxiety
__Stroke
__ Seizures
__ Radiation Treatment
__ Prostate Cancer
__ Pacemaker
__ Lymphoma
__ Hypertension
__ Lung Cancer
__ Leukemia
HIV/AIDS
__ Hyper/Hypo Thyroid
__ Valve Replacement
__ Arthritis
__ Hypercholesterolemia
__ None

Past Surgical History:

___ Appendix Removed
___ Mastectomy (Right, Left, Bilateral)
___ Breast Biopsy (Right, Left, Bilateral)
___ Breast Implants
___ Colectomy: Diverticulitis
___ Gallbladder Removed
___ PTCA
___ Biological Valve Replacement
___ Joint Replacement, Knee (Right, Left, Bilateral)
___ Joint Replacement within last 2 years
___ Kidney Removed (Right, Left)
___ Kidney Transplant
___ Prostate Removed: Prostate Cancer
___ Skin Biopsy
___ Squamous Cell Carcinoma Surgery
___ Ovaries Removed: Ovarian Cancer
___ Spleen Removed
___ Hysterectomy: Fibroids
___ Bladder Removed
___ Lumpectomy (Right, Left, Bilateral)
___ Breast Reduction
___ Colectomy: Colon Cancer Resection
___ Colectomy: IBD
___ Coronary Artery Bypass
___ Mechanical Valve Replacement
___ Heart Transplant
___ Joint Replacement, Hip (Right, Left,Bilateral)
___ Kidney Biopsy
___ Kidney Stone Removal
___ Ovaries Removed: Endometriosis
___ Prostate Biopsy
___ Basal Cell Cancer Surgery
___ Ovaries Removed: Cyst
___ Melanoma Surgery
___ Testicles Removed (Right, Left, Bilateral)
___ Hysterectomy: Uterine Cancer

PLEASE COMPLETE BOTH SIDES

Are you pregnant or lactating? ___Yes ___No
Have you ever had a Pneumonia vaccine? ___Yes___No

Skin Disease History:

___ Acne
___ Asthma
___ Blistering Sunburns
___ Eczema
___ Hay Fever/Allergies
___ Poison Ivy
___ Psoriasis
___ Other

___ Actinic Keratosis
___ Basal Cell Skin Cancer
___ Dry Skin
___ Flaking or Itchy Scalp
___ Melanoma
___ Precancerous Moles
___ Squamous Cell Skin Cancer

____

Do you have a pacemaker, defibrillator or mitral valve prolapse? **YES** or **No** (please circle)

Do you have any artificial joints, hips, knees, shoulders, heart valves, or any other prosthetic devices surgically Implanted pins, plates or screws? ____

Do you wear Sunscreen? ___________ If yes, what SPF? ______________
Do you tan in a tanning salon? __________
Do you have a family history of Melanoma? ___________ If yes, which relative(s)? __________________

Any other family medical history?____

Medications: (Please list all current medications including over the counter supplements and herbs)

____

____

Do any of your family members have hay fever, asthma, or eczema?

Allergies:
Are you allergic to Penicillin, sulfa drugs, lidocaine, neomycin, tape adhesives, iodine, or any other medications? Yes or ____No
If yes, please list: ____

____

____

____

Social History:

Marital Status:
___ Unspecified
___ Married-Name of Spouse ______________
___ Divorced
___ Single
___ Separated
___Widowed
___ Other:_____________________________

Alcohol use:
___ none
___ less than 1 drink per day
___ 3 or more drinks per day

Cigarette Smoking:
___ I have never smoked
___ I am a former smoker
___ I smoke less than daily
___ I smoke daily

Illicit Drug Use:
___ Drug Use
___ IV Drug use