Name _____ Date _____

Referring Physician _____ Date of Birth ___ / ___ / _____

Reason for Visit? _____ Best phone # to reach you to discuss results? _____ Okay to leave a message? ☐Y ☐N

Do you drink alcohol?	☐ Yes ☐ No	If yes, how many drinks per day? _____
Do you smoke?	☐ Yes ☐ No	If yes, how many packs per day? _____
Do you use illegal street drugs?	☐ Yes ☐ No	If yes, list _____

PAST MEDICAL HISTORY

Have you ever had any of the following?

Anxiety	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
Atrial Fibrillation	☐ Yes ☐ No
Cancer (non-skin)	☐ Yes ☐ No
COPD	☐ Yes ☐ No
Coronary Artery Disease	☐ Yes ☐ No
Depression	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
End Stage Renal Disease	☐ Yes ☐ No
Hearing Loss	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No
Seasonal Allergies	☐ Yes ☐ No
Seizures	☐ Yes ☐ No
Stroke	☐ Yes ☐ No
Thyroid Disease	☐ Yes ☐ No
Valve Replacement	☐ Yes ☐ No
None	
Other (list) _____	

SKIN DISEASE HISTORY

Please check all that apply

Actinic Keratosis	☐ Yes ☐ No
Basal Cell Skin Cancer	☐ Yes ☐ No
Melanoma (malignant)	☐ Yes ☐ No
Squamous Cell Skin Cancer	☐ Yes ☐ No
Precancerous Moles	☐ Yes ☐ No
(Atypical/Displastic)	☐ Yes ☐ No
History of bad or blistering sunburns?	☐ Yes ☐ No
Do you wear sunscreen?	☐ Yes ☐ No
If yes, what SPF?	_____
Do you have family history of skin cancer?	☐ Yes ☐ No
If yes, who?	

_____

PAST SURGICAL HISTORY

Please list previous surgical procedures

_____

_____

REVIEW OF SYMPTOMS

Are you currently experiencing any of the following?

Runny Nose/Itchy Eyes	☐ Yes ☐ No
Palpitations/Chest Pain	☐ Yes ☐ No
Leg Swelling	☐ Yes ☐ No
Fever/Chills	☐ Yes ☐ No
Unplanned Weight Loss	☐ Yes ☐ No
Cold/Heat Intolerance	☐ Yes ☐ No
Excessive Thirst/Hunger	☐ Yes ☐ No
Swallowing Problems	☐ Yes ☐ No
Mouth or Cold Sores	☐ Yes ☐ No
Nausea/Vomiting	☐ Yes ☐ No
Diarrhea/Constipation	☐ Yes ☐ No
Burning with Urination	☐ Yes ☐ No
Blood in Urine	☐ Yes ☐ No
Enlarged Glands/Lymph Nodes	☐ Yes ☐ No
Joint Pains	☐ Yes ☐ No
Muscle Aches	☐ Yes ☐ No
Headaches	☐ Yes ☐ No
Memory Loss	☐ Yes ☐ No
Depression	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No
Wheezing/Asthma	☐ Yes ☐ No
Shortness of Breath	☐ Yes ☐ No
Suppressed Immune System	☐ Yes ☐ No
Rash with Medication or Foods	☐ Yes ☐ No
Problems Healing	☐ Yes ☐ No
Scars/Keloids After Surgery	☐ Yes ☐ No

Other

_____

ALLERGIES

Please list all allergies and reactions

_____

MEDICATIONS

Please list all current medications (OTC, Herbal, Etc.)

_____

_____

PREFERRED PHARMACY

Please include location

_____

ALERTS

Are you currently experiencing any of the following?

Allergy to Latex or Tape	☐ Yes ☐ No	Allergy to Lidocaine	☐ Yes ☐ No	Allergy to Topical Antibiotic	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Artificial Joint in Past 2 Months	☐ Yes ☐ No	Accutane Used In Past 6 Months	☐ Yes ☐ No
Blood Thinner Use/Daily Aspirin	☐ Yes ☐ No	Defibrillator	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Medication Prior to Procedures	☐ Yes ☐ No	Rapid Heart Rate w/ Epinephrine	☐ Yes ☐ No	Pregnant/Breastfeeding	☐ Yes ☐ No
MRSA (Resistant Staph)	☐ Yes ☐ No				