Patient Name: ____ Height _______ Weight ____

MEDICAL HISTORY:

NONE

Anxiety

Arthritis

Asthma

Atrial Fibrillation

BPH (Prostrate Enlargement)

CVA (Stroke)

COPD

Coronary Artery Disease

Depression

Diabetes

Disease caused by Covid-19

End Stage Renal Disease

Epilepsy

GERD (Reflux)

Hypertension (Elevated Blood Pressure)

Hearing Loss

HIV/AIDS

Hypercholesterolemia

Hyperthyroidism

Hypothyroidism

Inflammatory Disease of Liver

Leukemia

Malignant Lymphoma

Lung Cancer

Breast Cancer

Colon Cancer

Prostate Cancer

Radiation Treatment

Bone Marrow Transplantation

Other Medical History

____

SURGICAL HISTORY:

NONE

Abdominoperineal resection

Breast Biopsy (R, L, Bilateral)

Prostate Biopsy

Coronary Artery (Heart) Bypass

Kidney Transplant

Excision of Basal Cell Cancer

Excision of Melanoma

Excision of Squamous Cell Carcinoma

Colostomy

Tubal ligation

Appendectomy

History of Cholecystectomy (*gallbladder removed*)

Colectomy (Colon Removed)

Excision of Liver

PTCA (Heart – Angioplasty)

Tissue Graft Heart Valve Replacement

Cystectomy (Bladder Removed)

TURP (Prostate Resection)

Hysterectomy

Kidney Biopsy

Lower Anterior Resection of Rectum

Lumpectomy (R, L, Bilateral)

Mastectomy (R,L, Bilateral)

Mech Heart Valve Replacement

Oophorectomy (ovary removal)

Pancreatectomy (Pancreas Removed)

Kidney Stone Removal

Portosystemic Shunt Operation

Prostatectomy (Prostate Removed)

SURGICAL HISTORY CONTINUED:

Splenectomy (Spleen Removed)

Skin Biopsy

Kidney Removed (R, L)

Total Joint Replacement:

Knee (R,L, Both) **Hip** (R,L, Both)

Transplant of Heart

Transplant of Liver

Testicles Removed (R, L, Bilateral)

Other_____________________

SKIN DISEASE HISTORY:

Acne

Actinic Keratosis (Precancer)

Dry Skin

Basal Cell Skin Cancer

Poison Ivy

Abnormal Moles (Atypical/Dysplastic)

Eczema

Asthma

Hay Fever/Allergies

Malignant Melanoma

Prutius (Itching of scalp)

Psoriasis

Squamous Cell Skin Cancer

Blistering Sunburns

Do you wear sunscreen? Yes No

If yes, what SPF? _______

Do you use a tanning bed? Yes No

MEDICATIONS:

Please enter all current medications including the dose if known:

1.______________________________

2.______________________________

3.______________________________

4.______________________________

5.______________________________

6.______________________________

7.______________________________

ALLERGIES:

Please enter Drug allergies and reactions:

1.______________________________

2.______________________________

3.______________________________

SMOKING HISTORY:

Never smoked

Quit: former smoker

Smokes less than ______ daily

Smokes daily

ALCOHOL USE:

Alcohol: none

Alcohol: less than 1 drink per day

Alcohol: 1-2 drinks per day

Alcohol: 3 or more drinks per day

SEXUAL HISTORY:

Not sexually active

Sexually active with one partner

Sexually active with more than one partner

Partner of the same sex

ILLICIT DRUG USE:

Drug use: Type:_________________

IV Drug Use: Type: ______________

REVIEW OF SYSTEMS:

Are you currently experiencing any of the following?

Problems with bleeding

Problems with healing

Problems with scarring (hypertrophic or keloid)

Rash

Hay fever

Chest pain

Fever or chills

Night sweats

Unintentional weight loss

Thyroid problems

Sore throat

Blurry vision

Abdominal pain

Bloody stool

Bloody urine

Joint aches

Muscle weakness

Neck stiffness

Headaches

Seizures

Cough

Shortness of breath

Wheezing

Anxiety

Depression

Other? ______________________

ALERTS:

Allergy to adhesive

Allergy to lidocaine

Allergy to topical ointments

Artificial heart valve

Artificial joints within last two years

Blood thinners

Defibrillator

MRSA

Pacemaker

Require premedication prior to procedures

Rapid heartbeat with epinephrine

Pregnancy or planning a pregnancy

History of Malignant Melanoma

Allergy to Latex

HIV Positive

Immunosuppression

Other significant medical issues:

FAMILY HISTORY:* *If Yes please indicate who.

Diabetes?
(Y,N)___________________________
_

Hypertension (High Blood Pressure)
(Y,N)___________________________
_

Malignant Melanoma
(Y,N)

____

Primary Care Physician:

____
_

Referring Physician:

____
_

Preferred Pharmacy:

____
_

____

____