

NAME: _____

DATE OF BIRTH: _____

History Form

Past Medical History: (please circle all that apply)

Anxiety	Coronary Artery	Thyroid Problems
Arthritis	Disease	Leukemia
Asthma	Depression	Lung Cancer
Atrial fibrillation	Diabetes	Lymphoma
Bone Marrow	End Stage Renal	Prostate Cancer
Transplantation	Disease	Radiation Treatment
Breast Cancer	GERD	Seizures
Colon Cancer	Hearing Loss	Stroke
COPD	Hepatitis	
	High Blood pressure	NONE
	HIV/AIDS	
	High Cholesterol	

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed	Joint Replacement within last 2 years
Bladder Removed	Kidney Biopsy (Nephrectomy)
Mastectomy (Right, Left, Bilateral)	Kidney Removed (Right, Left)
Lumpectomy (Right, Left, Bilateral)	Kidney Stone Removal
Breast Biopsy (Right, Left, Bilateral)	Kidney Transplant
Breast Reduction	Ovaries Removed: Endometriosis
Breast Implants	Ovaries Removed: Cyst
Colectomy: Colon Cancer Resection	Ovaries Removed: Ovarian Cancer
Colectomy: Diverticulitis	Prostate Removed: Prostate Cancer
Colectomy: IBD	Prostate Biopsy
Gallbladder Removed	TURP (Prostate Removal)
Coronary Artery Bypass	Spleen Removed
Mechanical Valve Replacement	Testicles Removed (Right, Left, Bilateral)
Biological Valve Replacement	Hysterectomy: Fibroids
Heart Transplant	Hysterectomy: Uterine Cancer
Joint Replacement, Knee (Right, Left, Bilateral)	
Joint Replacement, Hip (Right, Left, Bilateral)	NONE
Other _____	

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	
		NONE

Other _____

Do you wear Sunscreen? Yes No

If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)? _____

Medications: (Please enter all current medications)

Allergies: (Please enter all allergies)

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:

Alcohol- None
Alcohol- less than 1 drink per day
Alcohol -1-2 drinks per day
Alcohol-3 or more drinks a day

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Symptom	Yes	No
Chest Pain		
Shortness of breath		
Fever or chills		
Unintentional weight loss		
Night sweats		

Other Symptoms: _____

ALERTS: (please circle all that apply)

Allergy to Adhesive

Allergy to lidocaine

Allergy to topical antibiotics

Artificial heart valve

Artificial joint replacement

Blood thinners

Defibrillator

MRSA

Pacemaker

Require antibiotics prior to a surgical procedure

Rapid heart beat with epinephrine

Are you pregnant or currently trying to get pregnant?