NAME:_____
DOB:_____

History Form

Past Medical History: (please circle all that apply)

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

Past Surgical History: (please circle all that apply)

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

Skin Disease History: (please circle all that apply) Dry Skin

Acne
Actinic Keratoses Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Eczema
Flaking or Itchy Scalp

Hay Fever/Allergies
Melanoma
Poison Ivy
Squamous Cell Skin Cancer
Other:_____

Precancerous Moles
Psoriasis
NONE

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? YES/NO