Name:_____ Date:_____

PAST MEDICAL HISTORY: Please ✔ all that apply

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ BPH
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke

Other:_____

PAST SURGICAL HISTORY: Please ✔ all that apply

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Breast: Mastectomy R breast
- ☐ Breast: Mastectomy L breast
- ☐ Breast: Mastectomy both breasts
- ☐ Breast: Lumpectomy R breast
- ☐ Breast: Lumpectomy L breast
- ☐ Breast: Lumpectomy both breasts
- ☐ Breast: Biopsy (Right, Left, Bilateral)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colon removal for cancer
- ☐ Colon removal for diverticulitis
- ☐ Colon removal for IBD
- ☐ Gallbladder removal
- ☐ Coronary Artery Bypass
- ☐ PTCA
- ☐ Mechanical Heart Valve
- ☐ Pig Heart Valve
- ☐ Heart Transplant
- ☐ Joint Replacement Right Knee
- ☐ Joint Replacement Left Knee
- ☐ Joint Replacement Both Knees
- ☐ Joint Replacement Right Hip
- ☐ Joint Replacement Left Hip
- ☐ Joint Replacement Both Hips
- ☐ Joint Replacement within last 2yrs
- ☐ Kidney Biopsy
- ☐ Kidney Removal
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovary removal for endometriosis
- ☐ Ovary removal for ovarian cyst
- ☐ Ovary removal for ovarian cancer
- ☐ Ovary removal for endometriosis
- ☐ Ovary removal for endometriosis
- ☐ Prostate removal for cancer
- ☐ Prostate biopsy
- ☐ TURP
- ☐ Spleen removal
- ☐ Testicle removal
- ☐ Uterus removal for fibroids
- ☐ Uterus removal for cancer
- ☐ OTHER:_____
  _____
  _____

SKIN DISEASE HISTORY: Please ✔ check all that apply

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Dysplastic Nevi/Atypical moles

OTHER:_____

- ☐ Do you wear Sunscreen
  If yes, what SPF_____
- ☐ Do you use tanning beds
- ☐ Did you use tanning beds in the past
- ☐ Do you have a family history of melanoma
  If yes, which relative
  _____

Name:_____ Date:_____

MEDICATIONS: please list all current medications including non-prescription, over the counter, vitamins, etc

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

ALLERGIES:

_____ _____ _____ _____

_____ _____ _____ _____

SOCIAL HISTORY: Please ✔ check all that apply

- ☐ No Alcohol
- ☐ Less than one drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day
- ☐ Street Drug use
- ☐ Smokes cigarettes daily
- ☐ Smokes occasionally
- ☐ Former smoker
- ☐ Never smoked

Other_____

REVIEW OF SYSTEMS: Are you currently experiencing or have any of the following Please check ✓ all that apply

SYMPTOM

- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Problems with scarring
- ☐ Immunosuppression
- ☐ Changing mole
- ☐ Rash
- ☐ Stomach pain
- ☐ Anxiety
- ☐ Blood in stool
- ☐ Blood in urine
- ☐ Blurry vision
- ☐ Chest pain
- ☐ Cough
- ☐ Depression
- ☐ Fever or Chills
- ☐ Headaches
- ☐ Hay Fever
- ☐ Joint aches
- ☐ Muscle Weakness
- ☐ Neck Stiffness
- ☐ Night sweats
- ☐ Seizures
- ☐ Shortness of breath
- ☐ Sore throat
- ☐ Thyroid problems
- ☐ Unintentional Weight loss
- ☐ Wheezing

OTHER:_____

ALERTS: Please ✔ check all that apply

- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Artificial joint last 2 yrs
- ☐ Artificial heart valve
- ☐ Antibiotics needed prior to procedure
- ☐ Allergy to adhesives
- ☐ Allergy to topical antibiotic ointment
- ☐ Blood thinners
- ☐ Pregnant or planning a pregnancy
- ☐ Breast feeding
- ☐ Allergy Lidocaine
- ☐ Rapid heart beat with epinephrine
- ☐ Yeast infection with antibiotic
- ☐ Stomach upset with antibiotic

_____ _____

Patient Signature Date