PATIENT NAME: _____ Date: _____

Reason for today's visit:

_____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Coronary Artery
Depression
Diabetes
End Stage Renal
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Valve Replacement
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
None

Other: _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Basal Cell Cancer Surgery
Biological Valve Replacement
Bladder Removal
Colectomy (Colostomy)
Colectomy (Colon Cancer Resection)
Colectomy (Diverticulitis)
Colectomy (IBS)
Coronary Artery Bypass Surgery
Testicle Removal
Gallbladder Removal
Heart Transplant
Hysterectomy (Cervical Cancer)
Hysterectomy (Uterine Cancer)
Kidney Biopsy
Kidney Removal (right/left)
Kidney Stone Removal
Kidney Transplant
Lumpectomy (right/left/bilateral)
Mastectomy (right/left/bilateral)
Mechanic Valve Replacement
Melanoma Surgery
Ovary Removal (Ovarian Cancer)
Ovary Removal (endometriosis/cyst)
PTCA
Rectum APR
Skin Biopsy
Spleen Removal
Squamous Cell Carcinoma
Tubal Ligation

Joint Replacement: Hip (right/left/bilateral) Date_____
Joint Replacement: Knee (right/left/bilateral) Date_____
TURP

Other_____

Skin Disease History: (please circle all that apply)

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

Other: _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan at a tanning salon? Yes No
Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____

PATIENT NAME_____

Cautions: (please circle all that apply)

Have you ever had difficulty stopping bleeding? Yes No
Do you require antibiotics prior to surgical procedure? Yes No
Have you ever had an artificial joint replacement? Yes No
If yes when and what body location? _____
Do you have an artificial heart valve? Yes No
Do you have a pacemaker? Yes No
Do you have a defibrillator? Yes No
Are you pregnant or currently trying to get pregnant? Yes No

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____

Social History: (Please circle all that apply)

Currently smokes / has smoked in the past / Drug Use / Exposed to HIV/Other: _____

Alcohol: Less than 1 / 1-2 drinks per day / 3 or more per day

MALE ADULTS OLDER THAN 65: How many times in the past year have you had 5 or more drinks in one day
FEMALE ADULTS OLDER THAN 65: How many times in the past year have you had 4 or more drinks in one day

What is your occupation? _____

What are your hobbies? _____
_____

Race: Asian / American Indian / Caucasian / African American / Pacific Islander / other_____

Ethnicity: Non-Hispanic / Hispanic / Decline

Review of Systems: Circle if you are experiencing any of the following

Abdominal Pain	Anxiety	Bleeding Problems	Bloody Stool	Wheezing
Bloody Urine	Blurred vision	Changing Mole	Chest Pains	Thyroid Problems
Cough	Depression	Fever or Chills	Headaches	Sore Throat
Hay Fever	Joint Aches	Muscle Weakness	Neck Stiffness	Seizures
Shortness of Breath	Unintentional Weight Loss			
Melanoma History	Other:			

_____