Name: _____ **Date of Birth:** _____

Weight: _____ **Height:** _____ **Blood Pressure (if known):** _____

1. **Preferred language:** _____ 2. **Race/ethnicity:** _____

3. **What is your main concern for today's visit?:** _____

4. **<u>Tobacco Use</u>: Please choose the option that best describes your tobacco use**

☐ Never ☐ Current Some Day Smoker ☐ Current Every Day Smoker ☐ Former Smoker

For Current Tobacco users, select the option that best describes use:

☐ 1-3 cigarettes per day ☐ Up to 1 pack per day ☐ 1-2 packs per day ☐ 3 or more packs per day

5. **<u>Alcohol Use</u>: Please choose the option that best describes your alcohol use**

☐ Never ☐ Less than 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

6. Do you have any of these symptoms?

	Yes	No
Bleeds easily		
Problem with Healing		
Scar or Keloid formation		
Itching/Burning		
Rash		
Skin Thinning		
Hay Fever		
Facial Flushing		
Nausea		
Abdominal Pain		
Fatigue		
Headache		
Bloody Noses		
Joint Aches		
Muscle Pain		
Bloody stool		
Cough		
Fever/Chills		
Diarrhea		
Weight Loss		

7. Do you have any of the following conditions?

	Yes	No
Prone to infection		
Allergy to lidocaine		
Allergy to Neosporin		
Allergy to adhesive		
Blood thinners		
Defibrillator		
Pacemaker		
Problem with epinephrine		
Pregnant		
Planning Pregnancy		
Anxiety		
Arthritis		
Atrial Fibrillation		
Bone Marrow Transplant		
BPH		
Cancer		
COPD		
Coronary Artery Disease		
Depression		
Diabetes		

	Yes	No
End Stage Renal Disease		
GERD/Gastritis		
Hearing Loss		
Hepatitis		
Hypertension		
HIV/AIDS		
High Cholesterol		
Seizures		
Stroke		
Thyroid Disease		
Basal Cell Skin Cancer		
Squamous Cell Skin Cancer		
Melanoma		
Other:		

8. **List all medications you are currently taking (please be as specific as possible and include any non-prescription, aspirin, birth control pills, vitamins):**

_____

_____

_____

9. **List any allergies:**

_____

_____

10. **Preferred pharmacy (name and street):**

_____