**Past Medical History**: (mark all that apply)

* Anxiety
* Arthritis
* Asthma
* Atrial fibrillation
* Bone Marrow Transplantation
* BPH (prostate)
* 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 (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* None

**Past Surgical History**: (mark all that apply)

* Appendix Removed
* Bladder Removed
* Breast: Mastectomy (Circle: Right, Left, Both)
* Breast: Lumpectomy (Circle: Right, Left, Both)
* Breast Biopsy
* Breast Reduction
* Colectomy: Colon Cancer Resection
* Colectomy: Diverticulitis
* Colectomy: IBD
* Gallbladder Removed
* Heart: Coronary Artery Bypass
* Heart: PTCA
* Heart: Mechanical Valve Replacement
* Heart: Biological Valve Replacement
* Heart Transplant
* Joint Replacement, Knee (Circle: Right, Left, Both)
* Joint Replacement, Hip (Circle: Right, Left, Both)
* Kidney Biopsy
* Nephrectomy: Kidney Removed (Circle: Right, Left)
* Kidney Stone Removal
* Kidney Transplant
* Ovaries Removed: Endometriosis
* Ovaries Removed: Ovarian Cyst
* Ovaries Removed: Ovarian Cancer
* Prostate Removed: Prostate Cancer
* Prostate Biopsy
* Prostate: TURP
* **Skin Biopsy**
* **Basal Cell Cancer Surgery**
* **Squamous Cell Carcinoma Surgery**
* **Melanoma Surgery**
* Spleen Removed
* Testicles Removed (Circle: Right, Left, Bilateral)
* Hysterectomy: Fibroids
* Hysterectomy: Uterine Cancer
* Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* None

**Skin Disease History**: (mark all that apply)

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

**Do you have a family history of MELANOMA (NOT the same as basal cell or squamous cell carcinoma)? Yes No**

**If YES to melanoma, which relative(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If YES to melanoma, any other family history (breast, ovarian, pancreatic or prostate cancers)?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you had a Pneumonia Vaccine? Yes/NO (circle one) If Yes When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Height \_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_ BMI \_\_\_\_\_\_\_\_\_\_\_**

**Medications**: (enter all current medications and strengths) □ None

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drug Allergies**: (do they cause anaphylaxis, angioedema, diarrhea, fatigue, GI upset, hives, liver toxicity, or rash?)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ No Known Drug Allergies □ Latex

**Social History**: (mark all that apply)

**Sexual History:**

* Not sexually active
* Sexually active with one partner
* Sexually active with more than one partner
* Same Sex-Sexual partner

**Illicit Drug Use:**

* Drug Use
* IV Drug Use

**Alcohol (EtOH) Use:**

* None
* Less than 1 drink a day
* 1-2 Drinks per day
* 3 or more drinks per day

**How many times in the past year have you had 4 or more drinks in a day?**

* Less than Twice per Year
* More than Twice per Year

**Safety:**

* I feel safe at home.
* I do not feel safe at home.

**Cigarette Smoking (must answer):**

* Current every day smoker
* Current some day smoker
* Former smoker
* Never smoker

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Headaches Yes No

Dryness Yes No

Blurred Vision Yes No

Moodiness/Anxiety Yes No

Fever/Having signs of illness Yes No

Problems Healing/Scars Yes No

Other Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alerts**: Are you currently using or experiencing any of the following? (Please check yes or no for the following)

Blood thinners Yes No

Currently using Accutane/Biologic Yes No

Allergic to adhesive Yes No

Premedication prior to procedures Yes No

Pacemaker Yes No

Artificial Joints within past 2 years Yes No

Are you pregnant Yes No

If yes, due date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHARMACY** (You may ALSO list your mail-order pharmacy - include PHONE and FAX number)

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code (or nearby zip code) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (This is the fastest way for us to search)

Address (or major cross-roads if not known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_