History Form (please complete front and back)

Name_____**DOB**_____

Past Medical History: (please **circle** all that apply) NONE

Anxiety
Arthritis
Asthma
Arterial 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

Other _____

Past Surgical History: (please **circle** all that apply) NONE

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
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, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

Other _____

Skin Disease History: (please **circle** all that apply) NONE

Acne
Actinic Keratosis
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

Other _____

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:
EtOH- None
EtOH- less that 1 drink per day
EtOH- 1-2 drinks per day
EtOH- 3 or more drinks per day

Family History of Skin Cancer or Skin Disease(only parents and children)

_____

_____

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

Y	N		Y	N		Y	N	
__	__	bleeding problems	__	__	weight loss	__	__	muscle weakness
__	__	healing problems	__	__	thyroid problems	__	__	back or neck stiffness
__	__	scarring problem	__	__	recent sore throat	__	__	headaches
__	__	rash	__	__	bloody noses	__	__	seizures
__	__	dry skin	__	__	visual changes	__	__	cough
__	__	sun sensitivity	__	__	stomach or GI upset	__	__	shortness of breath
__	__	hay fever	__	__	bloody stool	__	__	wheezing
__	__	chest pain	__	__	bloody urine	__	__	anxiety
__	__	fever or chills	__	__	muscle or bone pain	__	__	depression
__	__	night sweats	__	__	joint aches or early morning stiffness			

ALERTS: (please **circle** all that apply)
Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial joint replacement
Blood thinners MRSA
Pacemaker
Require antibiotics prior to surgical procedure
Immunosuppressed by medication or condition
Rapid heart beat with epinephrine
Pregnant or currently trying to get pregnant

If you are over the age of 65 years old please answer below:

Have you received a pneumonia vaccination? Yes No

Do you have a health care proxy in the event your are unable to make your own medical decisions?
Yes No **If yes, Designees Name:**_____**Phone :**_____

Do you have a living will? Yes No If yes, please check appropriate plan:

- ☐ Do not intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
- ☐ Do not resuscitate: if my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life.
- ☐ Full cardiopulmonary resuscitation: I want full cardiopulmonary resuscitation efforts to be made.