MRN# ______________________

NAME: ____TODAYS DATE: _________________________

HEIGHT: ___________ WEIGHT: ____________ PHARMACY: ____

PERSONAL PAST/PRESENT MEDICAL HISTORY

Have you received the Flu Vaccine this year? ◯ YES DATE ________________ ◯ NO

Have you received the Pneumonia Vaccine? ◯ YES DATE ________________ ◯ NO

◯ Seasonal Allergies ◯ Diabetes ◯ Asthma ◯ Anxiety

◯ Latex Allergy ◯ Depression ◯ Hepatitis C ◯ Lymphoma/Leukemia

◯ Seizures ◯ Stroke ◯ High Blood Pressure ◯ Atrial Fibrillation

◯ High Cholesterol ◯ Pacemaker/Defibrillator ◯ Thyroid (Hypo / Hyper) ◯ Emphysema/COPD

◯ Organ Transplant ◯ HIV/AIDS ◯ Kidney Disease

◯ Pregnant ◯ YES ◯ NO (if yes how far along) ___________________ ◯ Breast Feeding ◯ YES ◯ NO

◯ Coronary Artery Disease (Heart Attack) When ________________________ ◯ Joint Replacement - When ________

◯ Arthritis (Osteoporosis, Rheumatoid, Psoriatic) ____

◯ Cancer Type: ____ (When) _________________________

◯ Surgeries ____

◯ None of the above

GENERAL HEALTH INDICATORS

◯ Fevers ◯ Night Sweats ◯ Change in Appetite ◯ Bruising Easily

◯ Problems Healing ◯ Fatigue ◯ Hypertrophic or Keloid Scars (raised, lumpy scar)

◯ Poor Balance ◯ Recently Fallen - When ____

◯ Other unusual or abnormal conditions ____

Do you feel safe at home? ◯ Yes ◯ No Do you have an advanced directive? ◯ Yes ◯ No

PERSONAL SKIN DISEASE HISTORY

◯ Eczema ◯ Psoriasis ◯ Actinic Keratosis ◯ Oral Herpes (cold sores) ◯ Acne

◯ Basal Cell Carcinoma ◯ Squamous Cell Carcinoma ◯ Melanoma

FAMILY SKIN CANCER HISTORY

◯ Melanoma If yes, which relative(s) ____

◯ Basal Cell Carcinoma ◯ Squamous Cell Carcinoma If yes which relative(s) ______________________

SOCIAL HISTORY

Illicit Drug Use ◯ No ◯ Yes Type ____________________________(How Often)________________________________

Alcohol Use ◯ No ◯ Yes (How Often) _____________________(How Much)________________________________

Cigarette Smoking ◯ No ◯ Quit (When) ___________ ◯ Yes (How often) ____________(How Many) ____________

MEDICATIONS

Name ___________________________Dose____________ Name ___________________________Dose____________

Name ___________________________Dose____________ Name ___________________________Dose____________

Name ___________________________Dose____________ Name ___________________________Dose____________

Name ____________________________Dose____________ Name ____________________________Dose____________

MRN# _______________________

DRUG ALLERGIES (List drugs and reactions) ◯ No ◯ Yes (if yes please list)

Name ____ Reaction____
Name ____ Reaction____
Name ____ Reaction____

Allergy to Lidocaine? ◯ YES ◯ NO
Allergy to epinephrine? ◯ YES ◯ NO
Allergy to adhesives or topical antibiotics? ◯ YES ◯ NO (If yes to what)____

COSMETICS

Are you interested in a cosmetic procedure? ◯ YES ◯ NO

If yes, what type?

Botox ◯ YES ◯ NO
Fillers ◯ YES ◯ NO

Contact Phone Number: ________________________Home ___________________________Cell
When is a good time to call? ___________________________ Ok to leave a message? ◯ YES ◯ NO