Patient History Form

Patient Name: _____ Date of Birth: _____ _____
Primary Care Physician: _____ Referring physician: _____
Pharmacy: _____ Address/Location: _____

Past Medical History (please circle all that apply):

Anxiety	Hepatitis
Arthritis	Hypertension/ High Blood Pressure
Artificial joints	HIV/AIDS
Asthma	Hypercholestrolemia/High Cholesterol
Atrial fibrillation	Hyperthyroidism/High Thyroid
BPH (benign prostatic hyperplasia)	Hypothyroidism/Low Thyroid
Bone Marrow Transplantation	Leukemia
Breast Cancer	Lung Cancer
Colon Cancer	Lymphoma
COPD (Emphysema)	Prostate Cancer
Coronary Artery Disease	Radiation Treatment
Depression	Seizures
Diabetes	Stroke
End Stage Renal Disease	Valve Replacement
GERD (Acid reflux)	NONE
Hearing Loss	

Other: _____

Past Surgical History (please list): _____

_____

_____

Skin Disease History (please circle all that apply):

Acne	Hay Fever/Allergies
Actinic Keratosis	Melanoma
Asthma	Poison Ivy
Basal Cell Carcinoma	Precancerous (Atypical) Moles
Blistering sunburns	Psoriasis
Dry skin	Squamous Cell Carcinoma
Eczema	NONE
Flaking or itching scalp	

Other: _____

Do you wear Sunscreen? YES NO

If yes, please list SPI _____

Do you tan in a tanning salon? YES NO

Do you have a family history of Melanoma? YES NO

If yes, please list relationship: _____

Do you have a family history o Basal Cell Carcinom: YES NO Squamous Cell Carminoma YES NO

Polycystic Ovarian Syndrome YES NO Autoimmune Disorders YES NO

If yes, please list relationship: _____

Current Symptoms (please circle all that apply):

Problems with bleeding	Immunosuppression
Problems with healing	Cough
Problems with scarring	Fever or chills
Abdominal pain	Night sweats
Blurry vision	Unintentional weight loss
Bloody stool	Thyroid problems
Joint Aches	Sore throat
Muscle pain/weakness	Bloody urine
Depression	Neck stiffness
Headaches	Seizures
Dizziness	Wheezing
Shortness of breath	Anxiety
Numbness/Tingling	Rash
Irregular menses	Hay Fever

Alerts (please circle all that apply):

Need antibiotics prior to procedures
Rapid heartbeat with epinephrine
Pregnant or planning a pregnancy
Currently Breastfeeding
Taking blood thinners
Allergy to adhesives
Allergy to Lidocaine (or other injectible numbing)
Allergy to topical antibiotic ointments
Latex allergy
Pacemaker

Please list all medications and supplements you are currently taking:

_____

_____

Please list any drug allergies (ex: antibiotics, aspirin, pain medication, neosporin, etc):

_____

_____

Social History (Please circle one):

Alcohol use: None Less than Daily Daily 1-2 per Day 3 or more per Day

Tobacco use: Never Former Less than Daily Daily

Occupation and Workplace: _____

Patient Signature: _____ Date _____