Patient Health History Form

Patient name: ___________________________ **Date of Birth:** ____
Primary Care Physician: __________________ **Address/Location:** ______________________________________
Referring Physician: _____________________ **Address/Location:** ______________________________________
Pharmacy: ______________________________ **Address/Location:** ______________________________________

How would you like to receive results from our clinic?
Phone number: __________________________
May we leave a detailed voicemail (labs/pathology) at this number? **Yes/No**
May we leave voicemail regarding other medical information at this number? **Yes/No**
Would you like to use the Patient Portal? **Yes/No**
Is there anyone we are authorized to give your results to? Please list: _______________________________
*****see results policy for further details

Past Medical History (please circle all that apply):

Anxiety	Hearing Loss
Arthritis	Hepatitis
Artificial heart valve	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	MRSA
Coronary Artery Disease	Prostate Cancer
Depression	Radiation Treatment
Diabetes	Seizures
End Stage Renal Disease	Stroke
GERD (Acid Reflux)	Valve Replacement
	NONE

Other:____

Past Surgical History (please list):____
____
____

Skin Disease History (please circle all that apply):
Do you wear Sunscreen? **YES** **NO** If so, please list SPF: ___________________________
Do you tan in a tanning salon? **YES** **NO**

Have you experienced any of the following (please circle all that apply):

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous (Atypical) Moles
Asthma	Flaking or Itching Scalp	Psoriasis
Basal Cell Carcinoma	Hay Fever/Allergies	Squamous Cell Carcinoma
Blistering Sunburns	Melanoma	**NONE**

Other: ____

<u>Family History</u>

Do you have a family history of Melanoma? YES NO If yes, please list relationship: _________________

Basal Cell Carcinoma?	**YES**	**NO**	**Squamous Cell Carcinoma**	**YES**	**NO**
Polycystic Ovarian Syndrome?	**YES**	**NO**	**Autoimmune Disorders**	**YES**	**NO**

If yes, please list personal or family history: ____

Current Symptoms (please circle all that apply):

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

Alerts (please circle all that apply):

Need antibiotics prior to procedures	Allergy to adhesives
Rapid heartbeat with epinephrine	Allergy to lidocaine or other injectable numbing
Pregnant or planning pregnancy	Allergy to topical antibiotic ointments
Currently breastfeeding	Latex allergy
Taking blood thinners	Pacemaker

Please list all medications and supplement you are currently taking (please do not include dosage):

____

____

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	Less than daily	Daily	Former	

Occupation and Workplace: ____

My signature indicates that all information on this form is accurate and complete and I've read the attached results information:

Patient Signature: ____ Date:______________________