Patient Name:	MR#:
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Chief Complaint: (reason, symptoms, condition or diagnosis that prompts your appointment)

Past Medical History

EYES	Yes	No	Yes - Details
Glaucoma	☐	☐	
EAR, NOSE AND THROAT			
Hearing difficulty	☐	☐	
Cochlear Implants	☐	☐	
Gum disease	☐	☐	
Sinus disease	☐	☐	
Cold sores (herpes infection)	☐	☐	
RESPIRATORY			
Asthma	☐	☐	
Emphysema (COPD)	☐	☐	
History of tuberculosis or positive PPD	☐	☐	
CARDIOVASCULAR			
Heart attack	☐	☐	
Congestive heart failure	☐	☐	
Pacemaker / defibrillator	☐	☐	
Heart murmur	☐	☐	
Artificial heart valve	☐	☐	
Rheumatic fever	☐	☐	
Deep venous thrombosis (blood clots)	☐	☐	
High blood pressure	☐	☐	
GASTROINTESTIONAL			
Hepatitis	☐	☐	
Liver disease	☐	☐	
Diabetes	☐	☐	
GENITOURINARY			
Kidney disease	☐	☐	
Bladder problem	☐	☐	
Prostate problem	☐	☐	
MUSCULOSKELETAL			
Artificial joint(s). If Yes, what year?	☐	☐	
Rheumatoid arthritis	☐	☐	

Patient Name:	**MR#:**
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NEUROLOGIC	Yes	No	Yes - Details
Stroke	☐	☐	
Seizure disorder	☐	☐	
Alzheimer's and/or dementia	☐	☐	
Deep brain stimulator	☐	☐	
HEMATOLOGIC			
History of cancer	☐	☐	
Anemia	☐	☐	
Anticoagulants / blood thinners	☐	☐	
ALLERGIC / IMMUNOLOGIC / INFECTIONS			
AIDS/HIV infection	☐	☐	
Autoimmune disease	☐	☐	
Prior Staph or MRSA infection	☐	☐	
Organ transplant recipient / immunosuppression	☐	☐	
Previous radiation therapy	☐	☐	
PSYCHIATRIC			
Severe anxiety or panic attacks	☐	☐	
Depression or bipolar disease	☐	☐	
Psychosis	☐	☐	
PERSONAL SKIN HISTORY			
Acne	☐	☐	
Eczema	☐	☐	
Psoriasis	☐	☐	
Lupus	☐	☐	
Skin cancer – melanoma	☐	☐	
Skin cancer – non-melanoma	☐	☐	
Tanning bed use	☐	☐	
Blistering sunburn(s)	☐	☐	
Healing problems	☐	☐	
Keloid scars	☐	☐	
Surgical complication	☐	☐	
Abnormal moles	☐	☐	
Previous Mohs Surgery	☐	☐	
FAMILY SKIN HISTORY – Please List Title	Yes	No	Title Family Member (Mother, Father, Grandmother, Grandfather, Brother, Sister, etc)
Are you Adopted?	☐	☐	
Acne	☐	☐	
Eczema	☐	☐	
Psoriasis	☐	☐	

Patient Name:			**MR#:**
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FAMILY SKIN HISTORY – (Continued)	Yes	No	Title Family Member
Skin cancer – melanoma	☐	☐	
Skin cancer – non-melanoma	☐	☐	
Abnormal moles	☐	☐	
Healing problems	☐	☐	
Keloid scars	☐	☐	
Surgical complications	☐	☐	
PAST MAJOR SURGERY	Yes	No	Yes - Details
Have you had any of the surgeries listed below?			
Heart Surgery	☐	☐	
Date:			
Shunt/stent	☐	☐	
Date:			
Pacemaker/Defibrillator	☐	☐	
Date:			
Joint replacement	☐	☐	
Date:			
Organ transplant	☐	☐	
Date:			
SOCIAL HISTORY	Yes	No	
Do you use alcohol?	☐	☐	
If yes, Do you drink socially?	☐	☐	
Do you drink daily?	☐	☐	
Smoking Status			
Never Smoked	☐	☐	
Former Smoker	☐	☐	
Every Day Smoker	☐	☐	
Social Smoker	☐	☐	
Smoker, current status unknown	☐	☐	
Unknown if ever smoked	☐	☐	
Amount			
> pack a day	☐	☐	
< a pack a day	☐	☐	
Started Date			
Ended Date			
Occupation (select one)	☐ Disabled	☐ Employed	☐ Homemaker ☐ Retired
☐ Student ☐ Unemployed ☐ List occupation or former occupation:			
☐ Other:			
	Yes	No	Yes - Details
Performs strenuous work?	☐	☐	

Patient Name:			**MR#:**
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	Yes	No	Yes - Details
Have you had the flu shot Within the last year?	☐	☐	
Where?	☐	☐	
Are you allergic to flu shot?	☐	☐	
Are you allergic to eggs?	☐	☐	
Are you taking Coumadin/Warfarin?	☐	☐	
If yes, current INR result:			
Date of test:			
MEDICATIONS Please list			Dosage
Are you allergic to any medications?	Yes	No	
If yes, please list medications and how you react:			

Review of Systems

Are you currently experiencing any of the following symptoms?

	YES	NO	Yes - Details
CONSTITUTIONAL			
Fevers / chills	☐	☐	
Weight loss or weight gain	☐	☐	
Fatigue	☐	☐	
Night sweats	☐	☐	
SKIN			
Painful, tender, red, crusty, bleeding or scaly lesion(s)	☐	☐	
Pigmented (darkly-colored) lesion(s)	☐	☐	
Growths	☐	☐	
New or changing moles	☐	☐	
Rash	☐	☐	
EYES			
Tearing	☐	☐	
Burning	☐	☐	
Blurred vision	☐	☐	
Irritation	☐	☐	
EAR, NOSE AND THROAT			
Bloody nose	☐	☐	
Recurrent sinus infections or sinus disease	☐	☐	
Mouth ulcers or gum disease	☐	☐	
Sore throat	☐	☐	
RESPIRATORY			
Shortness of breath	☐	☐	
Cough	☐	☐	
Wheezing	☐	☐	
CARDIOVASCULAR			
Chest pain	☐	☐	
Leg swelling	☐	☐	
Leg pain with exercise	☐	☐	
Shortness of breath with exertion	☐	☐	

Patient Name:			**MR#:**
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	YES	NO	Yes - Details
GASTROINTESTIONAL			
Abdominal pain	☐	☐	
Nausea/vomiting	☐	☐	
Blood in stools (rectal bleeding)	☐	☐	
Black, tarry stools (melena)	☐	☐	
Diarrhea	☐	☐	
GENITOURINARY			
Blood in urine	☐	☐	
Pain with urination	☐	☐	
Difficult / frequent urination	☐	☐	
MUSCULOSKELETAL			
Muscle aches	☐	☐	
Pain in joints / arthritis	☐	☐	
LYMPHATIC / HEMATOLOGIC			
Enlarged lymph nodes	☐	☐	
Excessive bleeding / clotting problem	☐	☐	
NEUROLOGIC			
Tingling / burning sensations	☐	☐	
Numbness, loss of sensation	☐	☐	
Headache	☐	☐	
Weakness	☐	☐	
Light-headedness or dizziness	☐	☐	
ALLERGIC / IMMUNOLOGIC / INFECTIONS			
Hay fever symptoms (sneezing; itchy, watery eyes)	☐	☐	
Active cold sore	☐	☐	
Chronic lymphocytic leukemia	☐	☐	
PSYCHIATRIC			
Severe anxiety	☐	☐	
Depression	☐	☐	
FEMALES			
Are you postmenopausal?	☐	☐	
Do you have abnormal menstrual bleeding?	☐	☐	
Are you pregnant?	☐	☐	
Due date:_____	☐	☐	
Breast-feeding?	☐	☐	
Planning to become pregnant?	☐	☐	

Thank you for completing these important forms. A copy will be added to your medical record.