Patient Name:	**MR#:**
Appointment Date:	**Page 1**

Chief Complaint: **(Please write reason, symptoms, condition or diagnosis that prompts your appointment)**

Past Medical History

PERSONAL SKIN HISTORY	YES	NO	Yes - Details
Melanoma	☐	☐	
Non-melanoma skin cancer (e.g. Basal cell carcinoma, squamous cell carcinoma or other)	☐	☐	
Tanning bed use	☐	☐	
Blistering sunburns	☐	☐	
Abnormal moles	☐	☐	
Eczema	☐	☐	
Psoriasis	☐	☐	
EYES, EARS, NOSE AN THROAT	YES	NO	Yes - Details
Glaucoma, cataracts, macular degeneration, or other eye disorder	☐	☐	
Cold sores (herpes infection)	☐	☐	
RESPIRATORY	YES	NO	Yes - Details
Asthma	☐	☐	
Lung disease (e.g. collapsed lung, interstitial lung disease, etc.)	☐	☐	
History of tuberculosis or positive PPD	☐	☐	
CARDIOVASCULAR	YES	NO	Yes - Details
Pacemaker / defibrillator	☐	☐	
Heart murmur	☐	☐	
Artificial heart valve	☐	☐	
High blood pressure	☐	☐	
High cholesterol	☐	☐	
ENDOCRINE	YES	NO	Yes - Details
Diabetes	☐	☐	
Thyroid disease	☐	☐	
GASTROINTESTINAL	YES	NO	Yes - Details
Inflammatory bowel disease (e.g. Ulcerative colitis or Crohn’s)	☐	☐	
Hepatitis	☐	☐	
Liver disease	☐	☐	
Reflux (GERD) and/or stomach ulcers	☐	☐	
GENITORURINARY	YES	NO	Yes - Details
Kidney disease	☐	☐	

Patient Name:			**MR#:**
Appointment Date:			**Page 2**
MUSCULOSKELETAL	YES	NO	Yes - Details
Arthritis (please specify: osteoarthritis, rheumatoid arthritis, psoriatic arthritis, or other type)	☐	☐	
Artificial joint(s). If Yes, what year?	☐	☐	
ALLERGIC / IMMUNOLOGIC / INFECTIONS	YES	NO	Yes - Details
AIDS/ HIV infection	☐	☐	
Autoimmune disease (please specify if known)	☐	☐	
Prior Staph or MRSA infection	☐	☐	
Organ transplant recipient/immunosuppression	☐	☐	
Previous radiation therapy	☐	☐	
Previous or current chemotherapy	☐	☐	
History of ANY cancer	☐	☐	
HEMATOLOGIC	YES	NO	Yes - Details
Bleeding disorder (e.g. hemophilia, platelet disorder, etc.)	☐	☐	
Clotting disorder (e.g. blood clots, DVT, or pulmonary embolus, etc.)	☐	☐	
Lymphoma or leukemia	☐	☐	
NEUROLOGIC	YES	NO	Yes - Details
Demyelinating disease (e.g. multiple sclerosis, Guillain–Barré syndrome, etc.)	☐	☐	
Migraines (if yes, do you have an "aura" such as sound or light preceding the migraine?)	☐	☐	
Parkinson’s disease	☐	☐	
Seizures	☐	☐	
Stroke	☐	☐	
PSYCHIATRIC	YES	NO	Yes - Details
Anxiety disorder	☐	☐	
Depression	☐	☐	
Bipolar disease or other mood disorder	☐	☐	
OTHER MEDICAL DISEASE (Please specify)			
PAST SURGICAL HISTORY	YES	NO	Yes - Details
Abdominal surgery	☐	☐	
Cosmetic surgery	☐	☐	
Eye surgery	☐	☐	
Ear/nose/throat surgery	☐	☐	
Heart surgery	☐	☐	
Spine or brain surgery	☐	☐	
Any other surgery? (If yes, please provide details)	☐	☐	
FEMALES ONLY: Have you had a hysterectomy or tubal ligation?	☐	☐	
FAMILY SKIN HISTORY	YES	NO	Which family members were affected? (Mother, Father, Grandmother, Grandfather, Brother, Sister, etc.)
Are you adopted?	☐	☐	
Acne	☐	☐	

Patient Name:			**MR#:**
Appointment Date:			**Page 3**
	YES	NO	
Eczema	☐	☐	
Psoriasis	☐	☐	
Melanoma	☐	☐	
Non-melanoma skin cancer	☐	☐	
Abnormal moles	☐	☐	
SOCIAL HISTORY	YES	NO	
Do you use alcohol?	☐	☐	
If yes, How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day?	☐ unknown		
	☐ 0		
	☐ 1		
	☐ 2		
	☐ 3 or more		
Smoking Status:	☐ Current every day smoker		☐ Current some day smoker
	☐ Former smoker		☐ Never smoker
	☐ Smoker, current status unknown		☐ Unknown if ever smoked
	☐ Heavy tobacco smoker		☐ Light tobacco smoker
Started Date:			
Ended Date:			
	YES	NO	
Have you had the flu shot within the last year? (If yes, select an option below)	☐	☐	
Influenza immunization previously received at home.	☐	☐	Date:
Influenza immunization previously received at work.	☐	☐	Date:
If you're 65 or older; have you ever received a pneumonia vaccine? If Yes, date	☐	☐	Date:
OCCUPATION			
What is your occupation?			

MEDICATIONS – Are you currently taking any medications? ☐ Yes ☐ No **If yes, please complete section below.

Medication name	Dosage

Patient Name:	MR#:
Appointment Date:	Page 4

Are you allergic to any medications? ☐ Yes ☐ No ** If yes, please complete section below.

Medication name	Reaction

Review of Systems

Are you currently experiencing any of the following symptoms?

ALLERGIC/IMMUNOLOGIC	YES	NO	Yes - Details
Hives	☐	☐	
Swollen lymph nodes	☐	☐	
Tongue swelling	☐	☐	
CARDIOVASCULAR	YES	NO	Yes - Details
Chest pain	☐	☐	
Dizziness	☐	☐	
Irregular heart beat	☐	☐	
Leg swelling	☐	☐	
CONSTITUTIONAL	YES	NO	Yes - Details
Fever	☐	☐	
Chills	☐	☐	
Fatigue/ Malaise	☐	☐	
Night sweats	☐	☐	
Weight loss	☐	☐	
EARS, NOSE, THROAT	YES	NO	Yes - Details
Hearing difficulty	☐	☐	
Nose bleeds	☐	☐	
Sore throat	☐	☐	
Sinus trouble	☐	☐	
Stuffy nose	☐	☐	
ENDOCRINE	YES	NO	Yes - Details
Diabetes	☐	☐	
Heat / cold intolerance	☐	☐	
Loss of hair	☐	☐	
EYES	YES	NO	Yes - Details
Blurred vision	☐	☐	
Double vision	☐	☐	
Dry eyes	☐	☐	
Eye irritation	☐	☐	

Patient Name:			**MR#:**
Appointment Date:			**Page 5**
GASTROINTESTINAL	YES	NO	Yes - Details
Abdominal pain	☐	☐	
Change in appetite	☐	☐	
Constipation	☐	☐	
Diarrhea	☐	☐	
Heartburn/ reflux	☐	☐	
Nausea/ vomiting	☐	☐	
GENITOURINARY	YES	NO	Yes - Details
Blood in urine	☐	☐	
Frequent urination	☐	☐	
Foamy urine	☐	☐	
Painful urination	☐	☐	
GYNECOLOGIC (Females Only)	YES	NO	Yes - Details
Currently pregnant	☐	☐	
Currently nursing	☐	☐	
Trying to get pregnant	☐	☐	
Using hormone replacement therapy	☐	☐	
HEMATOLOGY/ LYMPH	YES	NO	Yes - Details
Easy bruising	☐	☐	
Easy bleeding	☐	☐	
Gums bleed easily	☐	☐	
MUSCULOSKELETAL	YES	NO	Yes - Details
Back pain	☐	☐	
Joint pain or swelling	☐	☐	
Muscle pain	☐	☐	
Stiffness	☐	☐	
NEUROLOGICAL	YES	NO	Yes - Details
Decreased strength	☐	☐	
Headaches	☐	☐	
Memory loss	☐	☐	
Numbness	☐	☐	
Paralysis	☐	☐	
PSYCHIATRIC	YES	NO	Yes - Details
Anxiety	☐	☐	
Depression	☐	☐	
Difficulty sleeping	☐	☐	
Homicidal thoughts	☐	☐	
Mood changes	☐	☐	
Suicidal thoughts	☐	☐	
RESPIRATORY	☐	☐	
Cough	☐	☐	

<table>
<tr><td colspan="3">Patient Name:</td><td>MR#:</td></tr>
<tr><td colspan="3">Appointment Date:</td><td align="right">Page 6</td></tr>
<tr><td>Shortness of breath</td><td>☐</td><td>☐</td><td></td></tr>
<tr><td>Wheezing</td><td>☐</td><td>☐</td><td></td></tr>
<tr><td>SKIN</td><td></td><td></td><td></td></tr>
<tr><td>Itching/ burning</td><td>☐</td><td>☐</td><td></td></tr>
<tr><td>Itchy areas</td><td>☐</td><td>☐</td><td></td></tr>
<tr><td>New or changing moles</td><td>☐</td><td>☐</td><td></td></tr>
<tr><td>New rashes</td><td>☐</td><td>☐</td><td></td></tr>
<tr><td>Other skin concerns</td><td>☐</td><td>☐</td><td></td></tr>
<tr><td>Sores</td><td>☐</td><td>☐</td><td></td></tr>
</table>

Thank you for completing your Past Medical History and Review of System forms. These will be included in your medical record.