Patient Name:	MR#:
Appointment Date:	Page 1
Chief Complaint: (Reason for your visit)	

PAST MEDICAL HISTORY

Personal Skin History	Yes	No
Melanoma		
Non-Melanoma skin cancer (Basal cell carcinoma, squamous cell carcinoma, or other)		
Tanning bed use		
Blistering sunburns		
Abnormal moles		
Eczema		
Psoriasis		
Eyes, Ears, Nose, Throat	**Yes**	**No**
Glaucoma, cataracts, macular degeneration, other eye disorder		
Cold sores (herpes infection)		
Respiratory	**Yes**	**No**
Asthma		
Lung disease (collapsed lung, interstitial lung disease, etc)		
History of tuberculosis or positive PPD		
Cardiovascular	**Yes**	**No**
Pacemaker/Defibrillator		
Heart Murmur		
Artificial heart valve		
High blood pressure		
High cholesterol		
Endocrine	**Yes**	**No**
Diabetes		
Thyroid Disease		
Gastrointestinal	**Yes**	**No**
Inflammatory bowel disease (ulcerative colitis or Crohn's)		
Hepatitis		
Liver Disease		
Reflux (GERD) and/or stomach ulcers		
Genitourinary	**Yes**	**No**
Kidney Disease		
Musculoskeletal	**Yes**	**No**
Arthritis (circle type if yes: psoriatic, osteoarthritis, rheumatoid, or other)		
Artificial joint(s): If yes, what year? ____________		
Allergic/Immunologic/Infections	**Yes**	**No**
AIDS/HIV Infection		
Autoimmune Disease		
Prior Staph or MRSA infection		
Organ transplant recipient/immunosuppression		
Previous radiation therapy		
Previous or current chemotherapy		
History of ANY cancer		

Hematologic	Yes	No
Bleeding Disorder (hemophilia, platelet disorder, etc)		
Clotting Disorder (blood clots, DVT, pulmonary embolus, ect)		
Lymphoma or Leukemia		
Neurologic	**Yes**	**No**
Demyelinating disease (multiple sclerosis, Guillain-Barré syndrome, etc)		
Migraines (if yes, do you have an "aura" such as sound or light preceding migraine?)		
Parkinson's disease		
Seizures		
Stroke		
Psychiatric	**Yes**	**No**
Anxiety disorder		
Depression		
Bipolar disease or other mood disorder		

Past Surgical History	Yes	No
Abdominal surgery		
Cosmetic surgery		
Eye surgery		
Ear/nose/throat		
Heart surgery		
Spine or brain surgery		
Any other surgery (please provide detail below)		
Females Only: Hysterectomy of Tubal ligation		

Please provide additional information for any YES answers above:

____

____

____

____

____

____

____

____

____

____

____

____

Patient Name:	MR#:	Page 2

Does anyone in your FAMILY have any of the following?

	Yes	No	Family member affected (parent, grandparent, sibling)
Are you adopted?			
Acne			
Eczema			
Melanoma			
Non-melanoma skin cancer			
Abnormal moles			

The following questions are about YOU again:

SOCIAL HISTORY

	Yes	No
Do you use alcohol?		
If yes, how many times in the last year have you had more than 5 (for men) or 4 (for women or anyone over 65) 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
Start date:	End date:

Flu/Pneumonia Vaccine	Yes	No
Have you had a flu shot within the last year? If yes, select location below and list date.		
Administered at home (home health/pharmacy). Date:______________		
Administered at work. Date: _____________		
If 65 or older, have you ever received a pneumonia vaccine? Date: _____________		

What is your occupation?

Are you currently taking any medications? If so, please list below.	**Yes**	**No**
Medication	Dosage	Frequency (How often)?

Are you allergic to any medications? If so, please list below.	Yes	No
Medication	Reaction	

Patient name:	MR#:	Page 3

Review of Systems
Are you **CURRENTLY** experiencing any of the issues below?

Allergic/Immunologic	Yes	No
Hives		
Swollen lymph nodes		
Tongue swelling		
Cardiovascular	Yes	No
Chest pain		
Dizziness		
Irregular heart beat		
Leg swelling		
Constitutional	Yes	No
Fever		
Chills		
Fatigue/Malaise		
Night sweats		
Weight loss		
Ear, Nose, Throat	Yes	No
Hearing difficulty		
Nose bleeds		
Sore throat		
Sinus trouble		
Stuffy nose		
Endocrine	Yes	No
Diabetes		
Heat/cold intolerance		
Loss of hair		
Eyes	Yes	No
Blurred vision		
Double vision		
Dry eyes		
Eye irritation		
Gastrointestinal	Yes	No
Abdominal pain		
Change in appetite		
Constipation		
Diarrhea		
Heartburn/reflux		
Nausea/vomiting		
Genitourinary	Yes	No
Blood in urine		
Frequent urination		
Foamy urine		
Painful urination		
Gynecologic (Females Only)	Yes	No
Currently pregnant		
Currently nursing		
Trying to get pregnant		
Using hormone replacement therapy		

Hematology/Lymph	Yes	No
Easy bruising		
Easy bleeding		
Gums bleed easily		
Musculoskeletal	Yes	No
Back pain		
Joint swelling or pain		
Muscle pain		
Stiffness		
Neurological	Yes	No
Decreased strength		
Headaches		
Memory loss		
Numbness		
Paralysis		
Psychiatric	Yes	No
Anxiety		
Depression		
Difficult sleeping		
Homicidal thoughts		
Mood changes		
Suicidal thoughts		
Respiratory	Yes	No
Cough		
Shortness of breath		
Wheezing		
Skin	Yes	No
Itching/burning		
Itchy areas		
New or changing moles		
New rashes		
Other skin concerns		
Sores		

Please provide additional information for any YES answers above:

____

____

____

____

____

____

____

____

____

____