PATIENT NAME _____ **DATE**_____

REASON FOR VISIT _____

_____

PATIENT PAST MEDICAL HISTORY

		DETAILS
-No Pertinent Past Medical History	□	
Asthma	□	
Bleeding Disorder	□	
Breast Cancer	□	
Cancer	□	
Chest Pain/tightness	□	
Diabetes	□	
Eczema	□	
Heart Disease	□	
High Blood Pressure	□	
Hives	□	
Kidney Stones	□	
Other	□	
Stroke	□	
Thyroid Disorder	□	
Tuberculosis	□	
Ulcers	□	
Xray Therapy	□	

IMPORTANT INFORMATION

		DATE	DETAILS
Currently Pregnant	□		
Planning Pregnancy, How soon?	□		
Defibrillator	□		
Knee replacement	□		
Hip replacement	□		
Valve replacement	□		
HIV History	□		
Hepatitis	□		
Heart Murmur	□		
Pacemaker	□		
Transplants	□		
Latex Allergy	□		
Other	□		
None	□		

FAMILY HISTORY

		NOTES
-No Relevant Family History	□	
-Unknown – Adopted	□	
Autoimmune Disorders	□	
Cancer	□	
Other	□	
Skin Cancer	□	

HISTORY OF SKIN CANCER

□ None □ Personal history of skin cancer □ Personal history of melanoma □ Family history of skin cancer

PATIENT PAST SURGERIES/ HOSPITALIZATIONS (IF NONE, PLEASE WRITE NONE)

	SURGERY/HOSPITALIZATON	DATE	NOTES
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

SMOKING STATUS

Smoking Status	
Started	
Ended	
Cessation Counseling (OFFICE ONLY)	

PATIENT ALLERGIES (IF NONE, PLEASE WRITE NONE)

	ALLERGY	REACTION	NOTES
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

PATIENT CURRENT MEDICATIONS (IF NONE, PLEASE WRITE NONE)

	DRUG	DOSAGE
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

MEDICAL HISTORY VERIFICATION

All information provided above is accurate and complete to the best of my knowledge	PATIENT INITIALS	PARENT OR GUARDIAN INITIALS	DATE