Name: ______________________ Date of Birth: ___________ Account #____________

Preferred Pharmacy: ____________________________ Location: _____________________

Family Physician: ________________________ Referring Physician: _____________________

PAST MEDICAL HISTORY (please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH (benign prostatic Hyperplasia)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis A, B or C
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other ______________ ______________
- ☐ None

PAST SURGICAL HISTORY

- ☐ Appendix (appendectomy)
- ☐ Bladder (cystectomy)
- ☐ Breast Biopsy
- ☐ Breast Lumpectomy (both)
- ☐ Breast Lumpectomy (left)
- ☐ Breast Lumpectomy (right)
- ☐ Breast Mastectomy (both)
- ☐ Breast Mastectomy (left)
- ☐ Breast Mastectomy (right)
- ☐ Colon (colectomy) Colon Cancer Resection
- ☐ Colon (colectomy) Diverticulitis
- ☐ Colon (colectomy) Inflammatory Bowel
- ☐ Colon: Colostomy
- ☐ Gallbladder (cholecystectomy)
- ☐ Heart Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA (angioplasty)
- ☐ Joint Replacement: Hip (both)
- ☐ Joint Replacement: Hip (left)
- ☐ Joint Replacement: Hip (right)
- ☐ Joint Replacement: Knee (both
- ☐ Joint Replacement: Knee (left)
- ☐ Joint Replacement: Knee (right)
- ☐ Kidney: Biopsy
- ☐ Kidney: Nephrectomy
- ☐ Kidney: Stone Removal
- ☐ Kidney: Transplant
- ☐ Liver: Hepatectomy
- ☐ Liver: Transplant
- ☐ Liver: Shunt
- ☐ Ovaries: Endometriosis
- ☐ Ovaries: Ovarian Cancer
- ☐ Ovaries: Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate: Biopsy
- ☐ Prostate: Cancer
- ☐ Prostate: Transurethral Resection (TURP)
- ☐ Rectum: Abdominal Perineal Resection (CAPR)
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen: Splenectomy
- ☐ Testicles: Orchiectomy
- ☐ Uterus: (hysterectomy) Fibroids
- ☐ Uterus: (hysterectomy) Uterine Cancer
- ☐ Uterus: (Hysterectomy) Cervical Cancer
- ☐ Other: ______________ ______________
- ☐ None

Name: ____________________________

SKIN DISEASE HISTORY

□ Acne	□ Dry Skin	□ Precancerous Moles
□ Actinic Keratosis (Pre-Skin Cancer)	□ Eczema	□ Psoriasis
	□ Flaking or Itchy Scalp	□ Squamous Cell Carcinoma
□ Basal Cell Carcinoma	□ Melanoma	□ Other ________________ _________________
□ Blistering Sunburns	□ Poison Ivy	□ None

Do you wear sunscreen? □ Yes □ No If yes, what SPF? _____________

Do you tan in a tanning salon? □ Yes □ No

Family history of melanoma? □ Yes □ No If yes, relative: _________________________

Medications (list all prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary supplements:

Medication Name	Dosage	Frequency	Route

Drug Allergies: _______________________ _________________________ __________________________

If yes, describe reaction: ______________________ ____________________ ________________________

SOCIAL HISTORY

Tobacco Products:

□ Current every day smoker (tobacco) □ Former smoker-Date you quit smoking _________ □ Never

□ Current every day smoker (cigarettes/vapor) □ Cigar smoker

Alcohol:

□ None □ Less than 1 drink/day □ 1-2 drinks daily □ 3 or more drinks daily

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than **65**? ______________

Have you ever tested positive for TB? □ Yes □ No

REVIEW OF SYMPTOMS (**Current** problem with any of the following? Please check all that apply)

Problems with bleeding? □ Yes □ No
Problems with healing? □ Yes □ No
Problems with scarring? □ Yes □ No

Abdominal Pain □ Yes □ No
Anxiety □ Yes □ No
Bloody Stool □ Yes □ No
Bloody Urine □ Yes □ No
Blurry Vision □ Yes □ No
Chest Pain □ Yes □ No
Cough □ Yes □ No
Depression □ Yes □ No
Dizziness □ Yes □ No
Fever/Chills □ Yes □ No
Grey discoloration of skin □ Yes □ No
Hay Fever □ Yes □ No
Headaches □ Yes □ No
Immunosuppression □ Yes □ No
Joint Aches □ Yes □ No
If yes, what year _______
Night Sweats □ Yes □ No
Rashes/Hives □ Yes □ No
Seizures □ Yes □ No
Shortness of Breath □ Yes □ No
Sleeplessness □ Yes □ No
Sore Throat □ Yes □ No
Thyroid Problems □ Yes □ No
Unintentional Weight Loss □ Yes □ No

Wheezing □ Yes □ No
Red Eye □ Yes □ No
Tearing □ Yes □ No
Eye Pain □ Yes □ No
Uncontrolled Blood Pressure □ Yes □ No
Elevated Blood Sugar □ Yes □ No
Allergy to adhesives □ Yes □ No
Allergy to Lidocaine □ Yes □ No
Allergy to topical antibiotic ointment □ Yes □ No
Artificial Heart Valves □ Yes □ No
Artificial joints in the last 2 years □ Yes □ No
Blood thinners □ Yes □ No
Defibrillator □ Yes □ No
MRSA □ Yes □ No
Pacemaker □ Yes □ No
Currently pregnant
or planning pregnancy □ Yes □ No
Premedication prior to procedure □ Yes □ No
Rapid heartbeat w/epinephrine □ Yes □ No

Latex Allergy: □ Yes □ No

Signature of Responsible Party **Date**