MEDICAL HISTORY FORM

PATIENT INFORMATION

Name:	Date of Birth:	Account #:

Latex allergy?	Any drug allergies?	Pharmacy:
❑ Yes ❑ No	❑ Yes ❑ No	

MEDICAL SYMPTOMS

Please check all the 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
- ❑ Hypertension
- ❑ HIV/AIDS
- ❑ Hypercholeserolemia
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Leukemia
- ❑ Lung cancer
- ❑ Lymphoma
- ❑ Prostate cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke
- ❑ Other _____ _____ _____
- ❑ None

Have you had any surgeries in the following organs

Please check all that apply

- ❑ Appendix: (appendectomy)
- ❑ Bladder: (cystectomy)
- ❑ Breast: Breast Biopsy
- ❑ Breast: Lumpectomy (both breasts)
- ❑ Breast: Lumpectomy (left breast)
- ❑ Breast: Lumpectomy (right breast)
- ❑ Breast: Mastectomy (both breasts)
- ❑ Breast: Mastectomy (left breasts)
- ❑ Breast: Mastectomy (right breasts)
- ❑ 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: Kidney Biopsy
- ❑ Kidney: Kidney Stone Removal
- ❑ Kidney: Kidney Transplant
- ❑ Liver: Hepatectomy
- ❑ Liver: Liver Transplant
- ❑ Liver: Shunt
- ❑ Ovaries: (oophorectomy): Endometrosis
- ❑ Ovaries: (oophorectomy): Ovarian Cancer
- ❑ Ovaries: Tubal Ligation
- ❑ Pancreas: Pancreatectomy
- ❑ Prostate: (prostatectomy): Prostate Biopsy
- ❑ Prostate: (prostatectomy): Prostate Cancer
- ❑ Prostate: (prostatectomy): TURP (transurethral resection)
- ❑ Rectum: APR (abdominal perineal resection)
- ❑ Rectum: Low anterior resection
- ❑ Skin: Basal Cell Carcinoma
- ❑ Skin: Melanoma
- ❑ Skin: Skin Biopsy
- ❑ Skin: Squamous Cell Carcinoma
- ❑ Spleen: (splenectomy)
- ❑ Testicles: (orchiectomy)
- ❑ Uterus: (hysterectomy): Fibroids
- ❑ Uterus: (hysterectomy): Uterine Cancer
- ❑ Uterus: (hysterectomy): Cervical Cancer
- ❑ Other _____ _____ _____ _____ _____
- ❑ None

Have you had any of the following conditions:

- ❑ Acne
- ❑ Actinic Keratosis (pre skin cancer)
- ❑ Basal Cell Skin Cancer
- ❑ Blistering Sunburns
- ❑ Flaking or Itch Scalp
- ❑ Hay Fever/Allergies
- ❑ Melanoma
- ❑ Poison Ivy

❑ Dry Skin ❑ Eczema	❑ Precancerous Moles ❑ Psoriasis ❑ Squamous Cell Skin Cancer ❑ Other _____ _____ ❑ None	
Do you wear sunscreen?	❑ Yes ❑ No If Yes, what SPF? _____	
Do you tan in a tanning salon?	❑ Yes ❑ No	
Do you have a family history of melanoma?	❑ Yes ❑ No If yes, which relative?	
	❑ Mother ❑ Father ❑ Sister ❑ Brother ❑ Daughter ❑ Son ❑ Uncle ❑ Aun ❑ Nephew	❑ Niece ❑ Grandmother ❑ Grandfather ❑ Grandson ❑ Granddaughter ❑ Other _____ _____ ❑ None

Are you currently taking any of the following? ❑ Coumadin/Wafarin ❑ Pradaxa ❑ Effient ❑ Plavix ❑ Aspirin

Please list all **medications**, including any over the counter, that you currently take:

_____

_____

_____

List any medication allergies:

_____

_____

_____

SOCIAL HISTORY

Alcohol:
❑None
❑ Less than 1 drink per day
❑ 1-2 drinks daily
❑ 3 or more drinks daily

Tobacco Products Use?
❑ Current every day smoker
❑ Former every day smoker
❑ Never

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

REVIEW OF SYSTEMS

History or 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
Immunosupression	❑ Yes ❑ No
Hay fever	❑ Yes ❑ No
Chest Pain	❑ Yes ❑ No
Fever or Chills	❑ Yes ❑ No
Night sweats	❑ Yes ❑ No
Unintentional weight loss	❑ Yes ❑ No
Thyroid problems	❑ Yes ❑ No
Sore throat	❑ Yes ❑ No
Blurry vision	❑ Yes ❑ No
Abdominal pain	❑ Yes ❑ No
Bloody stool	❑ Yes ❑ No
Bloody urine	❑ Yes ❑ No
Joint aches	❑ Yes ❑ No
Muscle weakness	❑ Yes ❑ No
Neck	❑ Yes ❑ No
Seizures	❑ Yes ❑ No
Cough	❑ Yes ❑ No
Shortness of breath	❑ Yes ❑ No
Wheezing	❑ Yes ❑ No
Anxiety	❑ Yes ❑ No
Depression	❑ Yes ❑ No
Allergy to adhesive	❑ Yes ❑ No
Allergy to Lidocaine	❑ Yes ❑ No
Allergy to topical antiobiotic ointments	❑ Yes ❑ No
Artificial heart valves	❑ Yes ❑ No
Artificial joints within past 2 years	❑ Yes ❑ No
Blood thinners	❑ Yes ❑ No
Defibrillator	❑ Yes ❑ No
MRSA	❑ Yes ❑ No
Pacemaker	❑ Yes ❑ No
Premedication prior to procedures	❑ Yes ❑ No
Rapid heart beat with epinephrine	❑ Yes ❑ No
Pregnancy or planning a pregnancy	❑ Yes ❑ No

Patient/Guardian signature *Date*