Patient Name:_____**Date of Birth**_____

Reason for Today's Visit_____

How long have you had this problem?_____

Referred by:_____

Have you ever had dental anesthesia? (Lidocaine) _____Yes _____No
Any bad reactions?_____
What kind of reaction?_____

Do you develop skin rashes in reaction to: _____Medication, _____Food, _____Bandages, _____Environment, _____Topical Creams or Ointments, Other

_____

Medical History Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Heart Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Lupus
Hepatitis/Liver Disease
High Blood Pressure
HIV/AIDS
High Cholesterol
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
Autoimmune disorder
None
Other _____

Patient Name:_____**DOB:**_____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Plastic Surgery/Botox/Fillers
Other _____

Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None

Patient Name:_____**DOB:**_____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None
Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No
Have you ever had a blistering sunburn? Yes No

Family History:

Arthritis
Asthma
Allergies
Excessive Dry Skin
Hayfever
Lupus
Psoriasis
Sinus Problems
Vitiligo
Melanoma
Other Skin Cancer What Type_____
Other Skin Condition_____

If yes to any of the above Family History state which relative next to condition.

Medications: (Please enter all current medications)

_____
_____
_____

Allergies to Medications: (Please enter all allergies)

_____
_____
_____

Patient Name:_____**DOB:**_____

Social History: (Please circle all that apply)

Cigarette Smoking:

- Never smoked
- Quit: What year started? _____ What year stopped?_____
- How many years of smoking?_____
- If currently smoking how many packs per day?
- Do you use chewing tobacco?

Illicit Drug Use:

- Drug Use
- IV Drug Use

Alcohol Use:

- Alcohol: none
- Alcohol: less than 1drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Sexual Activity:

- Not sexually active
- Sexually active with one partner
- Sexually active with more than one partner
- Sexually active with same sex partner

Other_____

Occupation and workplace:_____

Please provide your Pharmacy name and Phone number

Patient Name:_____**DOB:**_____

Review of Systems: Are you currently experiencing any of the following?

Symptom	**Yes**	**No**
Diabetes		
Rash		
High Blood Pressure		
Fever or Chills		
Muscle or joint pain		
Problems taking Medication		
History of MRSA		
Travel outside the Country		
Excessive Dry or Sensitive Skin		
Allergies, seasonal or contact, Hayfever		
Sinus Problems		
Other skin problems		
Lupus or other autoimmune disease		
Alopecia areata		
Eczema		
Vitiligo		
Thyroid Problems		
New Medications incl OTC, supplements		
History of Acute Illness		
Recent Labs		
Toxin Exposure		
Stress or anxiety		
Recent weight loss or gain		
Multiple Sclerosis		
Arthritis, Type if known		
Asthma		
Psoriasis		
Herpes or cold sores		
Chest Pain		
Blood Clots		
Inflammation of veins		
Heart Disease		
Night Sweats		
Sore Throat		
Blurry Vision		
Gastrointestinal problems		
Kidney disease		
Dialysis		

Patient Name:_____**DOB:**_____

Review of Systems Cont: Are you currently experiencing any of the following?

Symptom	**Yes**	**No**
Muscle Weakness		
Bloody Urine or Stool		
Neck stiffness		
Headaches		
Seizures		
Cough		
Depression		
Lung Disease		
Anemia		
Suicidal ideation		

Alerts: Are you currently experiencing any of the following?

Artificial joints within the past two years		
Defibrillator		
Pacemaker		
Other implants, what type?		
Transplant		
Hepatitis		
HIV/AIDS		
Allergy to Latex		

Patient Name:_____**DOB:**_____

Other Symptoms: _____

Signature of Patient/Parent/Legal Guardian Date