# A black and white logo  Description automatically generated with low confidenceMedical History

Patient Name: Date:

What is the reason for being seen today?

Do you have or have you ever had any of the following medical conditions?

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Y | N |  | Y | N |  | Y | N |  | Y | N |
| Anxiety |  |  | Colon Cancer |  |  | Hearing Loss |  |  | Leukemia |  |  |
| Arthritis/ Joint Pain |  |  | COPD |  |  | Hepatitis B or C |  |  | Lung Cancer |  |  |
| Asthma |  |  | Coronary Artery Disease |  |  | High Blood Pressure |  |  | Lymphoma |  |  |
| Atrial Fibrillation |  |  | Depression |  |  | HIV/AIDS |  |  | Prostate Cancer |  |  |
| BPH (Enlarged Prostate) |  |  | Diabetes |  |  | High Cholesterol |  |  | Radiation Treatment |  |  |
| Bone Marrow Transplant |  |  | Kidney Disease |  |  | Hyperthyroidism |  |  | Seizures/Epilepsy |  |  |
| Breast Cancer |  |  | Acid Reflux-GERD |  |  | Hypothyroidism |  |  | Stroke |  |  |
| Other: |

Have you had surgeries on the following organs?

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Y | N |  | Y | N |  | Y | N |  | Y | N |
| Appendectomy |  |  | Heart Bypass Surgery |  |  | Endometriosis |  |  | Melanoma |  |  |
| Bladder Surgery |  |  | Heart Transplant |  |  | Ovarian Cancer |  |  | Skin Biopsy |  |  |
| Breast Biopsy |  |  | Heart PTCA |  |  | Ovarian Cyst |  |  | Squamous Cell Cancer |  |  |
| Breast Lumpectomy |  |  | Joint Replacement |  |  | Tubal Ligation |  |  | Splenectomy |  |  |
| Breast Mastectomy |  |  | Area: | Pancreatectomy |  |  | Orchiectomy |  |  |
| Colon Cancer Resection |  |  | Kidney Biopsy |  |  | Prostate Biopsy |  |  | Fibroids |  |  |
| Diverticulitis |  |  | Kidney Stone |  |  | Prostate Cancer |  |  | Uterine Cancer |  |  |
| Bowel Disease |  |  | Kidney Transplant |  |  | Prostatectomy |  |  | Cervical Cancer |  |  |
| Colostomy |  |  | Liver Disease |  |  | Rectal Disease |  |  |  |  |  |
| Gallbladder Surgery |  |  | Liver Transplant |  |  | Rectal Resection |  |  |  |  |  |
| Heart Valve Replacement |  |  | Liver Shunt |  |  | Basal Cell Carcinoma |  |  |  |  |  |
| Other: |



Have you had the following skin conditions?

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Y | N |  | Y | N |  | Y | N |  | Y | N |
| Acne |  |  | Dry Skin |  |  | Melanoma (MM) |  |  | Squamous Cell Cancer |  |  |
| Pre-Cancerous Lesion |  |  | Eczema |  |  | Poison Ivy |  |  | Rosacea |  |  |
| Basal Cell Carcinoma |  |  | Flaking/Itchy Scalp |  |  | Precancerous Moles |  |  | Fever Blisters |  |  |
| Blistering Sunburns |  |  | Skin Rashes |  |  | Psoriasis |  |  | Keloids |  |  |
| Do you wear sunscreen? |  |  | Tanning bed use? |  |  | Problem Healing |  |  | Family HX of Melanoma |  |  |
| Other: |

Social History:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Y | N |  |
| Do you drink alcohol? |  |  | If yes, how often? |
| Do you smoke? |  |  | If yes, how many per day? |
| Do you chew tobacco? |  |  | If yes, how often? |
| Do you use illegal drugs? |  |  | If yes, what type and how often? |

Women only

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Y | N |  | Y | N |  | Y | N |  | Y | N |
| Are you pregnant? |  |  | Trying to get pregnant? |  |  | Breastfeeding? |  |  | Using contraception? |  |  |

# A black and white logo  Description automatically generated with low confidenceMedication List

Patient Name: Date of Birth: Please list all current medications including over the counter supplements.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Medication Name (if none, please write none) | Dosage | Number of times per day | Notes |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 3 |  |  |  |  |
| 4 |  |  |  |  |
| 5 |  |  |  |  |
| 6 |  |  |  |  |
| 7 |  |  |  |  |
| 8 |  |  |  |  |
| 9 |  |  |  |  |
| 10 |  |  |  |  |

Allergies (if none, please write none)

|  |  |
| --- | --- |
| Medications and/or other allergens | Type of reaction |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |
| 4 |  |  |
| 5 |  |  |
| 6 |  |  |
| 7 |  |  |
| 8 |  |  |
| Are you allergic to Lidocaine?  YES  NO | Are you allergic to Latex?  YES  NO |
| Are you allergic to Adhesive Tape?  YES  NO |

Patient or Legal Guardian Signature: Date:

Relationship to Patient:

Nurse/ Assistant Signature: Date:

Physician/ Midlevel Provider Signature: Date: