Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City / State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number (day): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number (night): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnic Group:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy Emergency Contact

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City or Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt. Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Medical History

**Select any of the following medical conditions you currently have:**

 Anxiety Disorder

 Arthritis

 Asthma

 Atrial Fibrillation

 Benign prostatic hyperplasia

Cerebrovascular accident

 Chronic obstructive lung disease

 Coronaryarteriosclerosis

 Depressive disorder

 Diabetes mellitus

Disease caused by 2019-nCoV

 Elevated blood pressure

 End-stage renal disease

 Epilepsy

 Gastroesophageal reflux disease

 Hearing Loss

Hepatitis

 HIV

 H/O Hypertension

 Hypercholesterolemia

 Hyperthyroidism

 Hypothyroidism

Inflammatory Disease of Liver

 Leukemia

 Malignant Lymphoma

 Malignant tumor of lung/breast/colon (which one)

Malignant tumor of Prostate

 Radiation Therapy

 Transplantation of bone marrow

 NONE

 Other

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Surgical History

**Have you had any surgeries on the following organs?**

Abdominoperineal resection (APR)

 Bilateral replacement of knee joints

 Biopsy of breast

 Biopsy of prostate

 Coronary artery bypass graft

Entire transplanted kidney

 Excision of basal cell carcinoma

 Excision of melanoma

 Excision of squamous cell carcinoma

 H/O: Colostomy

 H/O: Tubal ligation

 History of appendectomy

 History of bilateral mastectomy

 History of cholecystectomy

 History of colectomy

History of liver excision

 History of percutaneous transluminal coronary angioplasty

 History of tissue graft heart valve replacement

 History of total cystectomy

 History of transurethral prostatectomy

 Hysterectomy

 Kidney biopsy

 Low anterior resection of rectum

 Lumpectomy of breast

 Lumpectomy of left breast

 Lumpectomy of right breast

 Mastectomy of left breast

 Mastectomy of right breast

 Mechanical heart valve replacement

 Oophorectomy

 Pancreatectomy

 Percutaneous extraction of kidney stone

 Portosystemic shunt operation

 Prostatectomy

 Prosthetic arthroplasty of bilateral hips

 Splenectomy

 surgical biopsy of skin

 Total nephrectomy

 Total orchidectomy

 Total replacement of left hip joint

 Total replacement of right hip joint

 Total replacement of left knee joint

 Total replacement of right knee joint

 Transplantation of heart

Transplantation of liver

None

Other:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skin Disease History

**Have you had any of the following?**

 Acne

 Actinic Keratosis

 Asteatosis cutis

 Basal Cell Skin Cancer

 Contact dermatitis due to poison ivy

 Dysplastic nevus

 Eczema

 History of asthma

 History of Hay Fever

 Malignant Melanoma

 Pruritus of scalp

 Psoriasis

Squamous Cell Skin Cancer



Sunburn of second degree

NONE

 Other

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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

 Aunt

 Nephew

 Niece

 Grandmother

 Grandfather

 Grandson

 Granddaughter

 Other

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications

List all current medications include dosage and frequency:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies

List all allergies and reactions if known:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social History (Please check all that applies)

* Not sexually active
* Sexually active with one partner
* Same sex partner
* Drug use
* IV drug use
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Smoking Status (please choose one):**

|  |  |
| --- | --- |
| Current everyday smoker  Former smoker  Never smoker  **Alcohol consumption**:     * None * Less than 1 drink a day * 3 or more drinks a day * How many times In the past year have you had 4 or more drinks per day?\_\_\_\_\_\_\_\_\_ |  |
|  |  |

**Pneumonia vaccination** **YES** **NO**

**Do you have a health care proxy?** **YES** **NO**

Designee’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designee’s phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have a Living will?** **YES** **NO**

Review of Systems

**Please check yes or no for the following:**

|  |  |  |
| --- | --- | --- |
| Symptom | Yes | No |
| Allergy to adhesive – rash |  |  |
| New hair growth on face, chest or abdomen |  |  |
| New moles |  |  |
| Problems with bleeding/easy bruising |  |  |
| Problems with healing |  |  |
| Problems with scarring (Hypertrophic or keloid) |  |  |
| Rash |  |  |
| Sensitivity to sunlight |  |  |
| Significant change in existing moles |  |  |
| Significant hair loss |  |  |
| Significant, persistent or intermittent burning of the skin |  |  |
| Significant, persistent or intermittent itching of the skin |  |  |
| Currently having menstrual periods |  |  |
| Irregular menstrual cycle |  |  |
| Hay fever |  |  |
| Immunosuppression |  |  |
| Palpitations, irregular heart beat |  |  |
| Unintentional weight loss |  |  |
| Thyroid problems |  |  |
| Joint aches |  |  |
| Anxiety |  |  |
| Depression |  |  |

|  |
| --- |
|  |

Alerts

**Please check yes or no for the following:**

|  |  |  |
| --- | --- | --- |
| Symptom | Yes | No |
| Allergy to lidocaine – itching |  |  |
| Allergy to lidocaine – palpitations |  |  |
| Allergy to lidocaine – sweating |  |  |
| Allergy to topical antibiotic ointments |  |  |
| Allergy to – latex |  |  |
| Artificial heart valve |  |  |
| Artificial joints within past two years |  |  |
| Blood thinners |  |  |
| Defibrillator |  |  |
| MRSA |  |  |
| Pacemaker |  |  |
| Patient vasovagal |  |  |
| Personal history of malignant melanoma |  |  |
| Premedication prior to procedures |  |  |
| Rapid heartbeat with epinephrine |  |  |
| Pregnancy or planning pregnancy |  |  |