Medications: (Please list all medications. Please circle "No Medications" if you are not currently taking any.)

No Medications

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies: (Please list all known allergies and reactions. If none, please circle "No Known Drug Allergies".)

No Known Drug Allergies

_____	_____	_____
_____	_____	_____

Have you had a flu vaccine this year? **YES** **NO** If yes, date: _____

Have you previously had a pneumonia vaccine? **YES** **NO** If yes, date: _____

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

Do you have Medical Power of Attorney (for yourself)? **YES** **NO**

If yes, please list name _____

Social History: (Please circle the choice which applies)

- **Smoking Status:**
  - Current Every Day Smoker
  - Current Someday Smoker
  - Former Smoker
  - Never Smoked

Alcohol Use:

None
< 1 drink per day
1-2 drinks per day
3 or more drinks per day

Occupation:_____

Alerts: (Please circle all that apply)

• None • Allergy to adhesive • Allergy to latex • Allergy to lidocaine • Artificial valve replacement	• Artificial joint replacement • Blood thinners • Defibrillator • Keloid Scarring • MRSA	• Pacemaker • Require antibiotics prior to procedures • Rapid heartbeat with epinephrine • Other: _____ _____

Are you pregnant or currently trying to get pregnant? (Please Circle) **YES** **NO**

Review of Systems: Are you currently experiencing any of the following? (Please circle yes or no)

Are you generally in good health?	**YES**	**NO**
Do you have problems with bleeding?	**YES**	**NO**
Do you have problems with healing?	**YES**	**NO**
Do you have problems with scarring?	**YES**	**NO**
Do you currently have a rash?	**YES**	**NO**
Do you have any new skin lesions?	**YES**	**NO**
Do you have any changing skin lesions?	**YES**	**NO**

Patient Name: _____

Patient Name: _____ DOB: ____ /____ / ____

Preferred Language: _____ Race: _____

Ethnic Group: (please circle) Hispanic or Latino Not Hispanic or Latino Unknown I choose not to specify

Pharmacy (name/town/phone #): _____

Past Medical History: (Please circle all that apply)

- None
- Anxiety
- Arthritis
- Asthma
- Atrial fibrillation
- Bone Marrow Transplant
- BPH
- Breast Cancer
- Colon Cancer
- COPD
- Coronary artery disease
- Depression
- Diabetes
- End stage renal disease
- GERD
- Head trauma
- Hearing loss
- Hepatitis
- Hypertension
- HIV/AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- Other:
  _____
  _____
  _____
  _____

Past Surgical History: (Please circle all that apply)

- None
- Appendix Removed
- Bladder Removed
- Breast Biopsy (right, left, bilateral)
- Lumpectomy (right, left, bilateral)
- Mastectomy (right, left, bilateral)
- Colectomy
- Colostomy
- Gallbladder removed
- Coronary artery bypass
- Angioplasty (PTCA)
- Biological valve replacement
- Mechanical valve replacement
- Heart Transplant
- Hip Replacement (right, left, bilateral)
- Knee Replacement (right, left, bilateral)
- Kidney biopsy
- Kidney removed (right, left)
- Kidney stone removal
- Kidney transplant
- Hepatectomy
- Liver shunt
- Liver transplant
- Ovaries removed (endometriosis, cancer, cyst)
- Tubal ligation
- Pancreas removed
- Prostate removed (cancer, TURP)
- Rectal resection
- Spleen removed
- Testicles removed (right, left, bilateral)
- Hysterectomy (fibroids, uterine cancer, cervical cancer)
- Other: _____
  _____

Skin Disease History: (Please circle all that apply)

- None
- Acne
- Actinic Keratoses
- Basal cell skin cancer
- Blistering sunburns
- Dry Skin
- Eczema
- Flaking/itchy scalp
- Hay fever/allergies
- Melanoma
- Poison ivy
- Precancerous moles
- Psoriasis
- Squamous cell skin cancer

Do you wear sunscreen? (Please Circle) **YES** **NO** If yes, what SPF:_____

Do you tan in a tanning bed? (Please Circle) **YES** **NO**

Do you have a family history of Melanoma? (Please Circle) **YES** **NO** If yes, which relative(s):_____