

PATIENT NAME _____ DATE _____

REASON FOR VISIT _____

PATIENT PAST MEDICAL HISTORY

| | | <u>DETAILS</u> |
|------------------------------------|--------------------------|----------------|
| -No Pertinent Past Medical History | <input type="checkbox"/> | |
| Asthma | <input type="checkbox"/> | |
| Bleeding Disorder | <input type="checkbox"/> | |
| Breast Cancer | <input type="checkbox"/> | |
| Cancer | <input type="checkbox"/> | |
| Chest Pain/tightness | <input type="checkbox"/> | |
| Diabetes | <input type="checkbox"/> | |
| Eczema | <input type="checkbox"/> | |
| Heart Disease | <input type="checkbox"/> | |
| High Blood Pressure | <input type="checkbox"/> | |
| Hives | <input type="checkbox"/> | |
| Kidney Stones | <input type="checkbox"/> | |
| Other | <input type="checkbox"/> | |
| Stroke | <input type="checkbox"/> | |
| Thyroid Disorder | <input type="checkbox"/> | |
| Tuberculosis | <input type="checkbox"/> | |
| Ulcers | <input type="checkbox"/> | |
| Xray Therapy | <input type="checkbox"/> | |

IMPORTANT INFORMATION

| | | <u>DATE</u> | <u>DETAILS</u> |
|-------------------------------|--------------------------|-------------|----------------|
| Currently Pregnant | <input type="checkbox"/> | | |
| Planning Pregnancy, How soon? | <input type="checkbox"/> | | |
| Defibrillator | <input type="checkbox"/> | | |
| Knee replacement | <input type="checkbox"/> | | |
| Hip replacement | <input type="checkbox"/> | | |
| Valve replacement | <input type="checkbox"/> | | |
| HIV History | <input type="checkbox"/> | | |
| Hepatitis | <input type="checkbox"/> | | |
| Heart Murmur | <input type="checkbox"/> | | |
| Pacemaker | <input type="checkbox"/> | | |
| Transplants | <input type="checkbox"/> | | |
| Latex Allergy | <input type="checkbox"/> | | |
| Other | <input type="checkbox"/> | | |
| None | <input type="checkbox"/> | | |

FAMILY HISTORY

| | | <u>NOTES</u> |
|-----------------------------|--------------------------|--------------|
| -No Relevant Family History | <input type="checkbox"/> | |
| -Unknown – Adopted | <input type="checkbox"/> | |
| Autoimmune Disorders | <input type="checkbox"/> | |
| Cancer | <input type="checkbox"/> | |
| Other | <input type="checkbox"/> | |
| Skin Cancer | <input type="checkbox"/> | |

HISTORY OF SKIN CANCER

- None Personal history of skin cancer Personal history of melanoma Family history of skin cancer

PATIENT PAST SURGERIES/ HOSPITALIZATIONS (IF NONE, PLEASE WRITE NONE)

| | <u>SURGERY/HOSPITALIZATON</u> | <u>DATE</u> | <u>NOTES</u> |
|----|--------------------------------------|--------------------|---------------------|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |
| 10 | | | |

SMOKING STATUS

| | |
|---|--|
| Smoking Status | |
| Started | |
| Ended | |
| Cessation Counseling (OFFICE ONLY) | |

PATIENT ALLERGIES (IF NONE, PLEASE WRITE NONE)

| | <u>ALLERGY</u> | <u>REACTION</u> | <u>NOTES</u> |
|----|-----------------------|------------------------|---------------------|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |
| 10 | | | |

PATIENT CURRENT MEDICATIONS (IF NONE, PLEASE WRITE NONE)

| | <u>DRUG</u> | <u>DOSAGE</u> |
|----|--------------------|----------------------|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |
| 6 | | |
| 7 | | |
| 8 | | |
| 9 | | |
| 10 | | |

MEDICAL HISTORY VERIFICATION

| | | | |
|---|--------------------------------|---|--------------------|
| All information provided above is accurate and complete to the best of my knowledge | <u>PATIENT INITIALS</u> | <u>PARENT OR GUARDIAN INITIALS</u> | <u>DATE</u> |
| | | | |

