Medical History

Patient Name: _____ Date: _____

Date of birth: _____ Primary Care Physician: _____

Pharmacy Name and Location: _____

Reason for today's visit: _____

Medical History (Please check all that apply)

- ☐ NONE
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroidism (high)
- ☐ Hypothyroidism (low)
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Lung Cancer
- ☐ Prostates Cancer
- ☐ Radiation Treatment
- ☐ Seizure
- ☐ Stroke
- ☐ Other: _____

Surgical History (Please check all that apply)

- ☐ NONE
- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast biopsy
- ☐ Breast: Lumpectomy
  (Circle) Left Right Both
- ☐ Breast: Mastectomy
  (Circle) Left Right Both
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip
  (Circle) Left Right Both
- ☐ Joint Replacement: Knee
  (Circle) Left Right Both
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries: (Oophorectomy): Endometriosis
- ☐ Ovaries: (Oophorectomy): Ovarian Cancer
- ☐ Ovaries: (Oophorectomy): Ovarian Cyst
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ Other: _____

(Continued)

Skin Disease History

- ☐ NONE
- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Other: _____

☐ Sunscreen use
If so, what SPF? _____

☐ Tanning Salon Use
If so, currently or past? _____

☐ Family history of Melanoma
If so, who? _____

Medications

(Please list all ***current*** medications and supplements)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies

_____

Social History

- ☐ Smoker (18 years and older)
- ☐ History of tobacco use
- ☐ Alcohol use
- ☐ Pneumonia vaccine (65 years and older)
- ☐ Flu vaccine within the last year

Review of Systems

(Please check all that you ***ARE CURRENTLY EXPERIENCING***)

- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Problems with scarring (hypertrophic or keloid)
- ☐ Rash
- ☐ Immunosuppression
- ☐ Hay Fever
- ☐ Chest Pain
- ☐ Fever or Chills
- ☐ Night sweats
- ☐ Unintentional weight loss
- ☐ Thyroid problems
- ☐ Sore throat
- ☐ Blurry vision
- ☐ Abdominal pain
- ☐ Bloody stool
- ☐ Bloody urine
- ☐ Joint Aches
- ☐ Muscle Weakness
- ☐ Neck Stiffness
- ☐ Headaches
- ☐ Seizures
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Anxiety
- ☐ Depression

Alerts

- ☐ Allergy to Lidocaine
- ☐ Allergy to topical antibiotic ointments
- ☐ Artificial heart valve
- ☐ Artificial joints within the past *TWO years*
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Pacemaker
- ☐ Premedication prior to procedures
- ☐ Rapid heartbeat with epinephrine
- ☐ Pregnant: _____ weeks
- ☐ Planning pregnancy
- ☐ Hepatitis
- ☐ Diabetic
- ☐ Transplant patient
- ☐ Allergies to medications
- ☐ Breast feeding
- ☐ West Africa: Travel or Contact
- ☐ HIV/AIDS positive