Today's Date: ______________________ Chart #: ____________________

Patient Information

Name: ___________________________ **DOB:** _____________ **M:**____ **F:** ____ **Other:** ______

Email address: _____________________________ **Primary Care Physician:** _______________

Who referred you to our office? Dr. ____________________ **Other:** _____________________

Pharmacy: _______________________________ **Pharmacy Phone:** ______________________

Pharmacy Location: ____

PLEASE CIRCLE ALL THAT APPLY TO YOU OR CIRCLE *NONE*

Past Medical History

NONE
anxiety
arthritis
asthma
atrial fibrillation
stroke
COPD
heart disease
depression
diabetes
high blood pressure
dialysis/ESRD
reflux
hearing loss
HIV/AIDS
high cholesterol
thyroid disease
hepatitis B or C
leukemia/lymphoma
organ transplant
-type__________year______
radiation
cancer _________________

Do you use tanning beds?
_____Never_____Past_____Currently

Smoking Status:
_____Never _____Former_____Currently

Skin Disease History

NONE
acne
actinic keratosis (pre-cancers)
allergies/hay fever
basal cell carcinoma
blistering sunburns
eczema
melanoma -year_____location_______
pre-cancerous moles/abnormal moles
psoriasis
squamous cell carcinoma

Do you wear sunscreen? yes
If so, what SPF?_____

FAMILY history of skin cancer? yes no
If yes, who?___
If yes, type

Basal cell carcinoma	yes	no
Squamous cell carcinoma	yes	no
Malignant melanoma	yes	no

ARE YOU ALLERGIC TO ANY MEDICATIONS? Y/N

If yes please list the medication and what kind of reaction you had to each:

____

____

Are you pregnant, planning pregnancy or breastfeeding? yes/no

Do you have an advanced care plan/living will? Yes/No
If yes, who is your surrogate decision maker? ____

Chart #: ______________________

Medication List

Please list all medications that you take (including over-the-counter)
IF not taking any please write N/A

	Medication Name	Dosage	How often do you take it
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

****Please complete below section only if you are a new patient****

Review of Systems and Alerts

Please circle all that *currently* apply to you or circle "none"

Problems with Bleeding
Problems with Healing
Problems with Scarring
Defibrillator/Pacemaker
Artificial Heart Valve
Artificial Joints
Premedication Prior to Procedures
Allergy to adhesives
Allergy to lidocaine
Allergy to epinephrine
Allergy to topical antibiotics
Allergy to latex
Joint Aches

Muscles Weakness
Neck Stiffness
Cough
Wheezing
Anxiety
Night Sweats
Thyroid Problems
Blurry Vision
Rash
Abdominal pain
Bloody Stool
Bloody Urine

Seizures
Depression
Sore Throat
Immunosuppression
Fever/Chills
Chest Pain
Shortness of Breath
Headaches
Unintentional
Weight Loss

NONE