NAME:

PLEASE COMPLETE BOTH SIDES

Past Medical History (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation (Irregular Heartbeat)
Bone Marrow Transplant
BPH
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Other_____
None of the above

Past Surgical History

Appendix (Appendectomy)
Bladder (Cystectomy)
Breast: Breast Biopsy
Breast: Lumpectomy (Right or Left)
Breast: Mastectomy (Right or Left)
Colon: (Colectomy): Colon Cancer Resection
Colon: (Colectomy): Diverticulitis
Colon: Inflammatory Bowel Disease
Colon: Colostomy
Gallbladder (Cholecystectomy)
Heart: Biologic Valve Replacement
Heart: Coronary Artery Bypass Surgery
Heart: Heart Transplant
Heart: Mechanical Valve Replacement
Heart: PTCA
Joint Replacement: Knee (Right or Left)
Joint Replacement: Hip (Right or Left)
Kidney: Biopsy
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
Ovaries: Tubal Ligation
Prostate (Prostatectomy): Prostate Biopsy
Prostate (Prostatectomy): Prostate Cancer
Prostate (Prostatectomy): TURP
Rectum: APR
Rectum: Low Anterior Resection
Skin: Basal Cell Carcinoma
Skin: Melanoma
Skin: Skin Biopsy
Skin: Squamous Cell Carcinoma
Spleen (Splenectomy)
Testicles (Orchiectomy)
Uterus (Hysterectomy): Fibroids
Uterus (Hysterectomy): Uterine Cancer
Uterus (Hysterectomy): Cervical Cancer
Other_____
None of the above

OVER

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
Other_____

Do you use Sunscreen?
Yes No
If Yes, what SPF?
SPF_____
Do you tan in a tanning salon?
Yes No

Do you have a Family History of Melanoma?
Yes No

If Yes, which relative?
_____

Medications:

(Please enter all current medication without dosage)

_____
_____
_____
_____
_____
_____

Allergies:

(Please enter all medication allergies)

_____
_____

Social History (circle all that apply)

●Smoking Status
Daily Occasionally Former Smoker Never
●Drug Use
None Drug Use IV Drug Use
●Alcohol Use
None Less than 1 drink/day
1-2 drinks/day 3 or more/day

●I feel Safe at home
Yes No
●Exercise
Daily Weekly Monthly
●Caffeine Use
Daily Weekly Monthly
● Occupation & Workplace
_____

OVER