Patient Name: ______________________________ **DOB:** __________ **Marital Status:** ___________

Preferred Language: _____________________ **Race:** ________________________

Ethnic Group: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ I choose not to specify.

Primary Care Doctor: ________________________ **Referring Doctor:** _______________________________

Pharmacy name, address, and phone number: ____

Past Medical History: (please check all that apply)

Anxiety disorder	Disease caused by 2019-nCoV	Hyperthyroidism
Arthritis – Type: ________	Elevated Blood Pressure	Hypothyroidism
Asthma	End Stage Renal Disease	Leukemia
Atrial Fibrillation	Epilepsy	Malignant Lymphoma
Benign Prosthetic Hyperplasia	GERD	Malignant tumor of breast
Cerebrovascular Accident	H/O Hypertension	Malignant tumor of colon
COPD	Hearing loss	Malignant tumor of prostate
Coronary Arteriosclerosis	Hepatitis: A B C	Radiation treatment
Depressive disorder	HIV/AIDS	Transplantation of bone marrow
Diabetes Mellitus	Hypercholesterolemia	

Other:

Past Surgical History: (please check all that apply)

Abdominoperineal Resection	Hysterectomy
Bilateral replacement of knee joints	Kidney biopsy
Biopsy of breast (left, right, bilateral)	Low anterior resection of rectum
Biopsy of Prostate	Lumpectomy of breast (left, right, bilateral)
Coronary Artery bypass graft	Mastectomy of breast (left, right)
Entire transplanted kidney	Mechanical Valve replacement
Excision of Basal Cell Carcinoma	Oophorectomy
Excision of Melanoma	Pancreatectomy
Excision of Squamous Cell Carcinoma	Percutaneous extraction of kidney stones-fragmentation
H/O Colostomy	Portosystemic shunt operation
H/O Tubal Ligation	Prostatectomy
History of Appendectomy	Prosthetic arthroplasty of bilateral hips
History of Bilateral Mastectomy	Splenectomy
History of Cholecystectomy	Surgical biopsy of the skin
History of Colectomy	Total Nephrectomy
History of liver excision	Total Orchidectomy
History of PTCA	Total replacement of Hip (left, right, bilateral)
History of tissue graft heart valve replacement	Total replacement of knee joint (left, right)
History of total cystectomy	Transplantation of heart
History of transurethral prostatectomy	Transplantation of liver

Other:

Skin Disease History: (please check all that apply)

Acne	Dysplastic nevus of skin	Pruritus of scalp
Actinic Keratosis	Eczema	Psoriasis
Asteatosis Cutis	H/O Asthma	Squamous Cell Carcinoma
Basal Cell Carcinoma	H/O hay fever	Sunburn of second degree
Contact Dermatitis due to poison Ivy	Malignant Melanoma	

DO YOU WEAR SUNSCREEN? ☐ YES ☐ NO *If yes, what SPF:* _____

DO YOU TAN IN A TANNING SALON? ☐ YES ☐ NO

DO YOU HAVE A FAMILY HISTORY OF MALIGNANT MELANOMA? ☐ YES ☐ NO

If yes, which relative(s): ____

MEDICATIONS (please list all current medications including the dose and frequency): ☐ NO MEDICATIONS

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

DRUG ALLERGIES (please list all known allergies and reactions): ☐ NO KNOWN DRUG ALLERGIES

______________________________ ______________________________

______________________________ ______________________________

SOCIAL HISTORY:

Smoking status: ☐ Current smoker ☐ Current occasional smoker
Date you started smoking ______________Date you quit smoking. ______________
☐ Former smoker ☐ Never smoker

Alcohol use: ☐ None ☐ < 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day
How many times in the past year have you had 5 or more drinks in a day? _______________

Occupation: ____

ALERTS: (please call that apply)		
Allergy to adhesive	Artificial joint replacement	MRSA
Allergy to latex	Blood thinners	Pacemaker
Allergy to lidocaine	Defibrillator	Require antibiotics prior to procedure.
Artificial valve replacement	Keloid scarring	Rapid heartbeat with epinephrine

HEIGHT: ________ **WEIGHT:** _________

ARE YOU CURRENTLY PREGNANT? ☐ YES ☐ NO If yes how many weeks? _______
ARE YOU BREAST FEEDING? ☐ YES ☐ NO
ARE YOU CURRENTLY TRYING TO GET PREGNANT? ☐ YES ☐ NO
HAVE YOU HAD A FLU SHOT THIS SEASON? ☐ YES ☐ NO Date received: __________
HAVE YOU EVER HAD A PNEUMONIA SHOT? ☐ YES ☐ NO

REVIEW OF SYSTEMS: Are you currently experiencing any of the following? (Please check yes or no)

Symptom	Yes	No
Are you in generally good health?		
Do you have problems with bleeding?		
Do you have problems with healing?		
Do you have problems with scarring?		
Do you currently have a rash?		
Do you have any new skin lesions?		
Do you have any changing skin lesions?		