Patient Name: _____ Date of Birth: _____

**Reason(s) for today's visit:** _____

**Past Medical History:** (Please circle all that apply)

| | | | |
|---|---|---|---|
| Anxiety | COPD | High Blood Pressure | Seizures |
| Arthritis | Coronary Artery Disease | HIV/AIDS | Hyperthyroid |
| Asthma | Depression | High Cholesterol | Hypothyroid |
| Atrial Fibrillation | Diabetes | Leukemia | Pacemaker/Defibrillator |
| Bone Marrow | End Stage Renal Disease | Lung Cancer | Cancer – other type |
| Transplantation | GERD | Lymphoma | (specify below) |
| Breast Cancer | Hearing Loss | Prostate Cancer | |
| Colon Cancer | Hepatitis | Radiation Treatment | **NONE** |

Other: _____

**Past Surgical History:** (Please list all that apply) _____

_____

**Skin Disease History:** (Please circle all that apply)

| | | | |
|---|---|---|---|
| Acne | Blistering Sunburns | Hay Fever/Allergies | Psoriasis |
| Actinic Keratoses | Dry Skin | Melanoma | Squamous Cell Skin Cancer |
| Asthma | Eczema | Poison Ivy | |
| Basal Cell Skin Cancer | Flaking or Itchy Scalp | Precancerous Moles | **NONE** |

Other: _____

**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 Melanoma?** Yes / No If yes, which relative(s)? _____

**Family History - First Degree Relative Only [Mother/Father/Brother/Sister/Child]:** (If positive, circle all that apply)

| | | | |
|---|---|---|---|
| Arthritis | Diabetes | Heart Disease | Psoriasis |
| Cancer | Eczema | High Blood Pressure | |

**Females Only:**

| | | | |
|---|---|---|---|
| Are you Pregnant or Breast Feeding? | Yes / No | Are you Planning a Pregnancy? | Yes / No |
| Do you have a regular Cycle? | Yes / No | Are you on an Oral Contraceptive? | Yes / No |

**Medications/Vitamins:** (Please list all current medications and vitamins)_____

_____

_____ **Date**:_____ **Initial**:_____

**Allergies:** (Please list all allergies) _____

_____

**Social History:** (Please circle all that apply)

Cigarette Smoking: Never Smoked / Quit: Former Smoker / Smokes Less Than Daily / Smokes Daily

Alcohol Use: ETOH-None / ETOH-less than 1 drink per day / ETOH - 1-2 drinks per day / ETOH - 3 or more drinks per day

Other: _____

Patient Name: _____ Date of Birth: _____

To help our practice comply with government mandated programs, please complete this block in its entirety.

Language: _____

Race: (Please circle)

White
American Indian or Alaskan Native
Asian
Black or African American
Native Hawaiian or other Pacific Islander

Ethnicity: (Please circle)

Hispanic or Latino
Not Hispanic or Latino

Preferred Contact Method: (Please circle)

Patient Portal
Phone

**Primary Care Physician:** _____

**Pharmacy:**

Name:_____

Address: _____

**Do you currently have any of the following symptoms?** (Please check YES or NO)

| | | | | | |
|---|---|---|---|---|---|
| Acne | [ ] yes | [ ] no | Hayfever | [ ] yes | [ ] no |
| Anxious feelings | [ ] yes | [ ] no | Slow healing after injury | [ ] yes | [ ] no |
| Lengthy bleeding when cut | [ ] yes | [ ] no | Joint pain | [ ] yes | [ ] no |
| Breathing difficulties | [ ] yes | [ ] no | Keloids or thick scars | [ ] yes | [ ] no |
| Cardiovascular problems | [ ] yes | [ ] no | Muscle weakness | [ ] yes | [ ] no |
| Chest symptoms | [ ] yes | [ ] no | Nausea and vomiting | [ ] yes | [ ] no |
| Deepening of voice | [ ] yes | [ ] no | Pain with deep breaths | [ ] yes | [ ] no |
| Difficulty hearing | [ ] yes | [ ] no | Psychiatric or emotional difficulties | [ ] yes | [ ] no |
| Dry skin | [ ] yes | [ ] no | Reddening of the face | [ ] yes | [ ] no |
| Epilepsy / Seizures | [ ] yes | [ ] no | Seasonal allergies | [ ] yes | [ ] no |
| Excess hair growth | [ ] yes | [ ] no | Sores or ulcers in mouth | [ ] yes | [ ] no |
| Fatigue | [ ] yes | [ ] no | Stomach or intestinal problems | [ ] yes | [ ] no |
| Feeling of sand in eyes | [ ] yes | [ ] no | Unintentional weight loss | [ ] yes | [ ] no |
| Fever or Chills | [ ] yes | [ ] no | Unwanted hair | [ ] yes | [ ] no |
| Genital sores | [ ] yes | [ ] no | White patches in mouth | [ ] yes | [ ] no |
| GI symptoms with antibiotics | [ ] yes | [ ] no | Yeast infections with antibiotics | [ ] yes | [ ] no |