Past Medical History: (please circle all that apply)

- Anxiety
- Arthritis
- Asthma
- Atrial fibrillation
- Bone Marrow Transplantation
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Hearing Loss
- Hepatitis
- High Blood pressure
- HIV/AIDS
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- NONE

Other ____________________________________________________________________________________

Past Surgical History: (please circle all that apply)

- Appendix Removed
- Bladder Removed
- Mastectomy (Right, Left, Bilateral)
- Lumpectomy (Right, Left, Bilateral)
- Breast Biopsy (Right, Left, Bilateral)
- Breast Reduction
- Breast Implants
- Colectomy: Colon Cancer Resection
- Colectomy: Diverticulitis
- Colectomy: IBD
- Gallbladder Removed
- Coronary Artery Bypass
- Mechanical Valve Replacement
- Biological Valve Replacement
- Heart Transplant
- Joint Replacement, Knee (Right, Left, Bilateral)
- Joint Replacement, Hip (Right, Left, Bilateral)
- Joint Replacement within last 2 years
- Kidney Biopsy (Nephrectomy)
- Kidney Removed (Right, Left)
- Kidney Stone Removal
- Kidney Transplant
- Ovaries Removed; Endometriosis
- Ovaries Removed: Cyst
- Ovaries Removed; ovarian Cancer
- Prostate Removed: Prostate Cancer
- Prostate Biopsy
- TURP (Prostate Removal)
- Spleen Removed
- Testicles Removed (Right, Left, Bilateral)
- Hysterectomy: Fibroids
- Hysterectomy: Uterine Cancer
- NONE

Other ____________________________________________________________________________________
**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
- 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)? ______________________________________________________________________

**Alerts:** (please circle all that apply)

Have you ever had difficulty-stopping bleeding?  Yes    No

Do you require antibiotics prior to a surgical procedure? Yes    No

Have you had an artificial joint replacement?  
  If yes, when and what body locations? _______________________________________________________

Do you have an artificial heart valve?  

Do you have a pacemaker?  

Do you have a defibrillator? 

Are you pregnant or currently trying to get pregnant?  

**Medications:** (please enter all current medications)

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

**Allergies:** (please enter all allergies)

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________
Social History: (please circle all that apply)

**CIGARETTE SMOKING:**
- Currently Smokes
- Has Smoked in the Past
- Never Smoked
- Former Smoker

**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 ____________________________________________________________________________________

Preferred Language:______________________________________________________________________________

Race: _____________________________________ Ethnicity: ______________________________________

Preferred Pharmacy Name: _______________________________________________________________________

Phone #: ______________________________________________________________________________________

City or Zip Code:________________________________________________________________________________

Patient Signature:_________________________ Date: ____________________________