Name: _____ **Date:** _____

Reason for Today's Visit: _____

Mark All That Apply:

[ ] Anxiety [ ] Arthritis [ ] Asthma [ ] Atrial Fibrillation [ ] Benign Prostate Hypertrophy [ ] Bone Marrow Transplantation [ ] Breast Cancer [ ] Colon Cancer [ ] Chronic Obstructive Pulmonary Disease [ ] Coronary Artery Disease [ ] Depression [ ] Diabetes [ ] End Stage Renal Disease [ ] Gastroesophageal Reflux Dis. (GERD) [ ] Hearing Loss [ ] Hepatitis [ ] Hypertension [ ] HIV/AIDS	[ ] Hypercholesterolemia [ ] Hyperthyroidism [ ] Hypothyroidism [ ] Leukemia [ ] Lung Cancer [ ] Lymphoma [ ] Prostate Cancer [ ] Radiation Treatment [ ] Seizures [ ] Stroke **List any other medical conditions:**	[ ] Pregnant or planning a pregnancy [ ] Pacemaker and/or Defibrillator [ ] Artificial joints within past two years [ ] Artificial heart valve [ ] Need premedication or antibiotics prior to surgery [ ] Allergy to adhesive [ ] Allergy to latex [ ] Allergy to Lidocaine or anesthetics [ ] Blood thinners [ ] Rapid heart beat with epinephrine [ ] Yeast infections with antibiotics [ ] Stomach/bowel upset with antibiotics [ ] Heat / Cold intolerance [ ] Easy bruising [ ] Skin rash(s) [ ] New / Changing skin lesion(s) [ ] Hives / Eczema [ ] Hay fever and or seasonal allergies

Circle / List any surgical procedures you have had and the year on the following organs:

Appendix Bladder Breast Colon Gallbladder Heart Joints Kidneys Ovaries Prostate

Skin Spleen Testicles Uterus Any other areas:

Circle any of the following skin related conditions that you have had?

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 wear sunscreen? YES NO If yes, what SPF number:_____

Do you tan in a tanning salon or outdoors? YES NO

Do you have a family history of Melanoma? YES NO

If yes, circle the relative? Mother Father Sister Brother Daughter Son Uncle Aunt Nephew Niece

Grandmother Grandfather Grandson Granddaughter Other:

Medications: List all prescription and over-the-counter medications you are currently taking internally including by mouth or injection and topically:

Allergies: (List the drug and the reaction when it is taken)

Preferred Pharmacy: _____ **Phone Number:** _____

How many servings of alcohol do you drink per day? [ ] None. [ ] Less than 1. [ ] 1 –2. [ ] More than 2.

Smoking status: [ ]Never Smoker [ ]Former Smoker [ ]Current Everyday Smoker [ ]Current Some Day Smoker

How often do you exercise: [ ] Daily [ ] A few times a week [ ] A few times a month [ ] Never

Frequency of caffeine use: [ ] Daily [ ] A few times a week [ ] A few times a month [ ] Never

Do you use IV drugs? [ ]YES [ ] NO

What is your occupation? _____

What are your hobbies? _____

What animals have you been around? _____