MEDICAL HISTORY

Patient Name_____ **DOB**_____

Medications:

(You may write below or you can provide us with a Medication List)

Name of Medication: Dosage : Frequency: Route:

_____
_____
_____
_____
_____
_____
_____
_____

Allergies to Medications:

_____
_____
_____
_____

Major Surgeries:

_____
_____
_____
_____

Family History of Skin Cancer:

_____
_____
_____

History of: (Please Circle)

Blood Thinners or Bleeding Issues	**NO**	**YES**
High Blood Pressure	**NO**	**YES**
Artificial or Abnormal Heart Valve	**NO**	**YES**
Pacemaker or Defibrillator	**NO**	**YES**
Artificial Joints	**NO**	**YES**
Scarring/poor healing	**NO**	**YES**
Angina/ Chest Pain	**NO**	**YES**
Seizures	**NO**	**YES**
Organ Transplant or Immunosuppression	**NO**	**YES**
Infectious Disease (circle)	**NO**	**YES (CIRCLE) TUBERCULOSIS HEPATITIS HIV**

Social History: (Please circle)

Tobacco Use	**NO**	**YES**	Packs/day_____ Date started smoking _____ Interested in quitting? (circle) Yes No Thinking about quitting
Former Smoker	**NO**	**YES**	Date quit_____ Start date or # yrs of smoking _____
Smokeless Tobacco	**NO**	**YES**	How often?_____
Alcohol Use	**NO**	**YES**	Drinks/week_____
Recreational Drug Use	**NO**	**YES**	Type & How often_____
Sunscreen Use	**NO**	**YES**	Daily____ As needed_____ None_____
Tanning Bed Use	**NO**	**YES**	How often?_____

Preventative Care: (Please circle)

Did you receive a flu shot for the current Flu Season (Aug-March)? **NO YES** Approximate Date_____
If you are 65 years or older, have you ever received a pneumococcal vaccine (Pneumovax or pneumonia vaccine)? **NO YES** Approximate Date_____

Female Patients: (Please circle)

Are you or could you potentially be pregnant? **NO YES NA**
Are you breastfeeding? **NO YES NA**