MEDICAL HISTORY

Date:_____ **MRN #** _____

ATTENTION: If female, are you pregnant, nursing, possibly pregnant, or planning to become pregnant soon? _____

MEDICAL HISTORY

Select any of the following medical conditions that you have had:

____Anxiety
____Arthritis
____Asthma
____Atrial Fibrillation
____BPH/ Enlarged Prostate
____Bone Marrow Transplantation
____Breast Cancer
____Colon Cancer
____Chronic Obstr. Pulmonary Disease
____Coronary Artery Disease
____Depression
____Diabetes
____End Stage Renal Disease
____GERD
____Hay Fever / Seasonal Allergies
____Hearing Loss
____Hepatitis
____Hypertension
____HIV / AIDS
____Hypercholesterolemia
____Hypothyroidism or Hyperthyroidism
____Leukemia
____Lung Cancer
____Lymphoma
____Prostate Cancer
____Radiation Treatment
____Seizures
____Stroke
Other_____

PAST SURGICAL HISTORY

Please list any surgeries you have had and when they took place:

____Appendix (Appendectomy)
____Bladder (Cystectomy)
____Breast: Mastectomy (Right)
____Breast: Mastectomy (Left)
____Breast: Mastectomy (Both)
____Breast: Lumpectomy (Right)
____Breast: Lumpectomy (Left)
____Breast: Lumpectomy (Both)
____Breast: Breast Biopsy
____Breast: Breast Reduction
____Breast: Breast Implants
____Colon (Colectomy): Colon Cancer Resection
____Colon (Colectomy): Diverticulitis
____Colon (Colectomy): Inflammatory Bowel Disease
____Gallbladder (Cholecystectomy)
____Heart: Coronary Artery Bypass Surgery
____Heart: Mechanical Valve Replacement
____Heart: Biological Valve Replacement
____Heart: Heart Transplant
____Joint Replacement: Knee (Right)
____Joint Replacement: Knee (Left)
____Joint Replacement: Knee (Both)
____Joint Replacement: Hip (Right)
____Joint Replacement: Hip (Left)
____Joint Replacement: Hip (Both)
____Kidney: Kidney Biopsy
____Kidney: Nephrectomy
____Kidney: Kidney Stone Removal
____Kidney: Kidney Transplant
____Ovaries (Oophorectomy): Endometriosis
____Ovaries (Oophorectomy): Ovarian Cyst
____Ovaries (Oophorectomy): Ovarian Cancer
____Prostate (Prostatectomy): Prostate Cancer
____Prostate (Prostatectomy): Prostate Biopsy
____Prostate (Prostatectomy): TURP
____Skin: Skin Biopsy
____Spleen (Splenectomy)
____Testicles (Orchidectomy)
____Uterus (Hysterectomy): Fibroids
____Uterus (Hysterectomy): Uterine Cancer
Other _____

SKIN DISEASE HISTORY

____Acne
____Actinic Keratoses
____Atypical/Dysplastic Moles
____Basal Cell Skin Cancer
____Blistering Sunburns
____Dry Skin
____Eczema
____Flaking or Itchy Scalp
____Melanoma
____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

FAMILY HISTORY

Do you have a family history of:
Melanoma?_____Yes____No
If yes, which relative? _____
Basal or Squamous Cell Cancer? _____
___BCC ____SCC

Atypical/Dysplastic Moles?_____Yes____No

Any other important family history?

SMOKING HISTORY

___ Current everyday smoker
___ Current occasional smoker
___ Former smoker
___ Never smoked

ALLERGIES

☐ Check here if you have NO drug allergies

CURRENT PRESCRIPTIONS

☐ Check here if you take NO medications

Name of Medication	Dose

OVER-THE-COUNTER MEDICATIONS

(Vitamins, herbs, pain relievers, etc.)

Name of Medication	Dose

My Preferred Pharmacy is:

Location:_____

My Primary Doctor is:

Location: _____