PATIENT NAME:_____**DOB:**_____**WEIGHT:**_____

Primary Care Physician:_____ **Referrnig Physician:** _____

Reason for today's visit: _____

PLEASE PROVIDE THE FOLLOWING INFORMATION:

1. Please list all known drug allergies._____
2. Please list all medications you are currently taking.

   _____

   _____
3. Have you ever had any operations? Yes No If yes, please describe. _____

   _____
4. Have you ever been treated for any of the following **(please circle Yes or No for each, if Yes, please explain)**:

a. Constitutional Symptoms *(weight loss/gain, fever, etc.)*	Yes	No	_____
b. Eye Disorders	Yes	No	_____
c. Ear, Nose, Throat, and Mouth	Yes	No	_____
d. Respiratory Disorders (lung disease)	Yes	No	_____
e. Digestive Diseases	Yes	No	_____
f. Urinary/Bladder/Kidney Disease	Yes	No	_____
g. Blood Disorders	Yes	No	_____
h. Muscle/Skeletal Disorders	Yes	No	_____
i. Skin Disorders	Yes	No	_____
j. Neurologic Disorders	Yes	No	_____
k. Psychiatric	Yes	No	_____
l. Endocrine (diabetes, thyroid, etc.)	Yes	No	_____
m. Cardiovascular *(high blood pressure, heart disease)*	Yes	No	_____
n. Cancer	Yes	No	_____
o. Allergic/Immunologic	Yes	No	_____
p. Scarring (keloids, etc.)	Yes	No	_____
q. Hepatitis or HIV	Yes	No	_____
r. Advanced Care (Surrogate)	Yes	No	_____
s. History of Flu Vaccine	Yes	No	_____
t. History of Malignant Melanoma	Yes	No	_____
u. History of Pneumonia Vaccine	Yes	No	_____

5. Do you routinely *require antibiotics prior* to dental/surgical procedures due to a heart murmur, artificial heart valve, artificial joint, etc.? Yes No

6. Do you take an anticoagulant, such as Coumadin, Plavix, or Aspirin (please circle if applicable)? Yes No

7. Do you smoke or chew Tobacco? Yes No If former smoker then specify start/end date: _____

Specify current/past per day: _____ cigarettes/packs/dip/cigars/chew: _____

8. Do you drink Alcohol? Yes No

If yes, how many alcoholic beverages do you consume daily: 1-3: _____ 4-6: _____ 7-10: _____ 10+:_____

9. Do you have a history of Skin cancer? Yes No BCC SCC MM Abnormal Moles Other_____

Do you have a Family history of Skin cancer? Yes No BCC SCC MM Abnormal Moles Other_____

10. Do you have a history of Skin disease? Yes No Please Specify_____

Do you have a Family history of Skin disease? Yes No Please Specify_____

11. Sun exposure: o Daily o Weekly o Rarely o Use of sunblock o History of tanning bed use

12. FOR WOMEN ONLY: a. Are you pregnant or currently planning a pregnancy? Yes or No

b. Are you currently nursing? Yes or No

13. Family History (please specify disease and family member) Unknown Adopted

a. Autoimmune disorders _____

b. Colon Cancer_____

c. Diabetes_____

d. Glaucoma_____

e. High blood pressure_____

f. High cholesterol_____

g. Liver disease_____

h. Lung disease_____

i. Malignant Melanoma_____

j. Obesity_____

k. Premature Coronary Heart Disease_____

l. Skin cancer_____

m. Thyroid disease_____

Pharmacy Information

Preferred Pharmacy:_____ Phone Number: (___)_____

Address:_____