PATIENT HISTORY SHEET

Name: _____ Birthdate _____

Who is your primary care doctor (GP)? _____
Were you referred for this visit? YES NO
If so, by whom? _____

What pharmacy do you use? _____ Which location? _____
Medications:

CIRCLE ONE

Are you taking aspirin, Coumadin / warfarin, or any other blood thinners? YES NO
If yes, which one and what is your dosage? _____
List all other medications you are taking (or please supply a current list):

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Is there any medication to which you are truly allergic? _____
_____

Do you have seasonal allergies to pollen? _____
Medical History:

Accutane use	Yes ___ No ___		Diabetes	Yes ___ No ___	
Anemia	Yes ___ No ___		High blood pressure	Yes ___ No ___	
Arrhythmia – Atrial fib			High cholesterol	Yes ___ No ___	
or other irregular heart beat	Yes ___ No ___		Macular degeneration	Yes ___ No ___	
Arthritis of any kind	Yes ___ No ___		Melanoma of the skin	Yes ___ No ___	
Asthma	Yes ___ No ___		Neurologic disease		
Cancer of any organ, like breast or lung	Yes ___ No ___		(Parkinson's, epilepsy)	Yes ___ No ___	
Cancer of skin	Yes ___ No ___		Tanning bed use (ever ?)	Yes ___ No ___	
Connective tissue disease, like lupus	Yes ___ No ___		Thyroid disease	Yes ___ No ___	
C.O.P.D.	Yes ___ No ___				

Family History: Do you have a BLOOD RELATIVE with any of the following?

Skin cancer	Yes ___ No ___	If yes, whom? _____
Breast cancer	Yes ___ No ___	If yes, whom? _____
Pancreatic cancer	Yes ___ No ___	If yes, whom? _____
Bowel cancer	Yes ___ No ___	If yes, whom? _____
Thyroid disease	Yes ___ No ___	If yes, whom? _____
Connective tissue disease (such as lupus)	Yes ___ No ___	If yes, whom? _____

Review of Systems: Please check YES or NO for each of the following problems. If yes, please explain below.

Weight loss or gain	Yes ___ No ___	Diarrhea	Yes ___ No ___	
Fever	Yes ___ No ___	Burning with urination	Yes ___ No ___	
Muscle pain	Yes ___ No ___	Cold sores	Yes ___ No ___	
Joint pain	Yes ___ No ___	Abnormal scarring	Yes ___ No ___	
Depression or anxiety	Yes ___ No ___	Asthma / hayfever	Yes ___ No ___	
Trouble with ears, nose, mouth or throat	Yes ___ No ___	Blistering sunburns (ever?)	Yes ___ No ___	

If yes, please explain: _____

All Past Surgeries: _____
_____
_____

Smoking: Cigarette smoking – (Pick one) – NEVER SMOKED FORMER SMOKER SMOKING NOW
Does someone at home smoke around you? YES NO

Alcohol Use: Do you drink at all? YES NO If yes, in the past year – in one sitting / day – did you have more than 4 drinks if female OR 5 drinks if male? YES NO

Immunizations:
Have you had the flu vaccine within the past year? YES NO If yes, when? _____
Have you had the pneumonia vaccine ever? YES NO If yes, when? _____
Have you been tested for tuberculosis, either by blood test or skin test (PPD)? YES NO