PATIENT NAME:_____ **DOB:**_____

MEDICAL HISTORY

Age:_____ Male:_____ Female:_____Height:_____ Weight:_____

Indicate if you have ever had or been treated for the following:

	Yes	No	Is this a current condition?	Additional Notes
Alcoholism				
Allergy to local anesthetic				Type of reaction:
Anemia				
Arthritis				
Asthma				
Blood Disorder				
Cancer				Type:
Diabetes				Type: When diagnosed:
Drug addiction				
Heart surgery				Type: Dates:
Heart disease				Type:
Hepatitis A, B, or C				Type:
Heart attack/chest pain				
Hypertension / high blood pressure				
HIV+				
Keloids or scarring				
Kidney disease – acute renal failure				
Kidney disease – chronic renal failure				
Liver disease				
Lung disease				
Prolonged bleeding				
Psychiatric treatment				
Radiation treatment				Location:
Shortness of breath				
Skin cancer				Type: Location:
Stroke/TIA				
Thyroid problems				
Ulcers (GI)				
Other				
Other				

Surgical History: List all surgeries you have had and approximate dates

☐ Mastectomy_____ ☐ Hysterectomy_____
☐ Breast biopsy_____ ☐ C-section_____

_____ Date:_____
_____ Date:_____
_____ Date:_____
_____ Date:_____
_____ Date:_____
_____ Date:_____

Family History: Indicate if a member of your family has a history of:

	Yes	No	Which family member(s)
Skin cancer			
Melanoma			
Breast cancer			
Ovarian cancer			
BRCA testing done?			Results:

PATIENT NAME:_____ **DOB:**_____

Social History:

Smoking: ☐ Never smoked ☐ Quit smoking: when_____ ☐ Currently smoke: # packs per day: _____
Alcohol drinking: ☐ Do not drink ☐ Socially, occasionally ☐ Amount per week: _____

Medications Currently Taking: *(attach additional page if necessary)*

Name:_____Dosage:_____Reason:_____
Name:_____Dosage:_____Reason:_____
Name:_____Dosage:_____Reason:_____
Name:_____Dosage:_____Reason:_____
Name:_____Dosage:_____Reason:_____

Drug Allergies / Reactions: _____

Reason for today's visit? _____

Indicate if you are <u>currently experiencing</u> or being treated for any of the following:

Note: Anything not marked will be considered something you are NOT currently experiencing or being treated for so please review carefully.

General:		**Cardiovascular:**		**Dermatologic:**	
chills		arrhythmia		Cellulites	
fatigue		chest pain/pressure		Intertrigo / rashes	
fever		edema/swelling of limbs		Keloid scarring	
insomnia		high blood pressure		Lipoma	
recent illness		dizziness		Melanoma	
recent weight gain		**Respiratory:**		Scarring	
recent weight loss		asthma		Skin cancer	
Eyes:		chest congestion		Sores/wounds	
eye redness/erythema		cough		**Neurologic:**	
eye pain		**Gastrointestinal:**		Dizziness	
eye tearing		Abdominal pain		Headache	
eye tearing		Constipation		Mental status change	
eyelid edema/swelling		Diarrhea		Paresis/paralysis	
eyelid pain		Gas/bloating		**Psychiatric:**	
vision change		Nausea		Alcohol abuse	
visual field obstruction		Vomiting		Anxiety	
Ears/Nose/Throat:		Swelling		Depression	
deviated septum		**Genitourinary/nephrology:**		Drug abuse	
facial pain		Acute renal failure		**Endocrine:**	
facial swelling		Chronic renal failure		Diabetes – type:	
nasal discharge		Hernia		**Hematologic:**	
nasal obstruction		Pregnancy		Abnormal bleeding/bruising	
nasal pain		**Musculoskeletal:**		Anemia	
nasal trauma		Limb pain			

Any other conditions you are currently experiencing or being treated for?:_____

_____