Medical History

Name: _____

Past Medical History: (Please circle all that apply)

Anxiety	Coronary Artery Disease	HIV/AIDS	Allergies/Hay fever
Arthritis	Depression	High Cholesterol	Alcohol Abuse
Asthma	Diabetes	Leukemia	Cancer
Atrial Fibrillation	End Stage Renal Disease	Prostate Cancer	Gastrointestinal Disease
Bone Marrow Transplantation	GERD	Radiation Treatment	Heart Attack/Failure
BPH	Hearing Loss	Seizures	Liver/Lung/Kidney Disease
Breast Cancer	Hepatitis	Stroke	Lymphoma / Lupus
COPD	High Blood Pressure	Thyroid Problems	Multiple Sclerosis
Neurologic/Psychiatric Disorders	Organ Transplant	Serious Infection	Tuberculosis

NONE / Other: _____

Past Surgical History: (Please circle all that apply)

Appendix Removed	Joint Replacement, Hip (Right, Left, Bilateral)
Bladder Removed	Joint Replacement within last 2 years
Mastectomy (Right, Left, Bilateral)	Kidney Biopsy (Nephrectomy)
Lumpectomy (Right, Left, Bilateral)	Kidney Removed (Right, Left)
Breast Biopsy (Right, Left, Bilateral)	Kidney Stone Removal
Colectomy: Colon Cancer Resection	Kidney Transplant
Colectomy: Diverticulitis	Ovaries Removed: Endometriosis
Colectomy: IBD	Ovaries Removed: Cyst
Gallbladder Removed	Ovaries Removed: Ovarian Cancer
Coronary Artery Bypass	Prostate Removed: Prostate Cancer
Mechanical Valve Replacement	Prostate Biopsy
Biological Valve Replacement	TURP (Prostate Removal)
Heart Transplant	Testicles Removed (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)	Hysterectomy: Fibroids / Uterine Cancer

NONE

Other: _____

Name: _____

Skin Disease History: (Please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever / Allergies	Squamous Cell Skin Cancer
Blistering Sunburn	Melanoma	Keloid scars

NONE

Other: _____

Do you wear sunscreen? Yes No If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No If yes, which relative? _____

Medications: (please enter all current medications)

_____ _____

_____ _____

_____ _____

Allergies: (please enter all allergies)

_____ _____

_____ _____

Social History: Please circle all that apply)

Currently Smokes	Former Smoker	Never Smoked

Family History of Illness: (Only first-degree relatives)

_____

_____

Alerts: (please circle all that apply)

Blood Thinners	Rapid heartbeat with Epinephrine	Trying to get pregnant
Defibrillator	Pacemaker	Pregnant / Breast Feeding

Allergy to antibiotic ointments, adhesives, or latex

Do you have: Bleeding problems, heart valve problems, endocarditis, neurologic shunt, or poor wound healing?

Primary Care Physician: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____