Patient History

Name: _____ Date: _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Hepatitis
HIV/AIDS
Stroke
COPD
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Radiation Treatment
Hypertension
Colon Cancer
Hyperthyroidism
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Breast Cancer
Seizures
Valve Replacement
Depression
None

Other Medical History: _____

_____

Past Surgical History: (please circle all that apply)

Joint Replacement, Knee
(Right, Left, Bilateral)
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Skin Biopsy
Skin: Squamous Cell Cancer Surgery
Colectomy: Colon Cancer Resection
Colectomy: IBD
Gallbladder Removed
Heart: Coronary Artery Bypass
Heart Surgery
Testicles Removed (Right, Left, Bilateral)
Ovaries: Endometriosis
Ovaries Removed; Ovarian Cancer
Prostate Removed: Prostate Cancer
Joint Replacement, Hip
(Right, Left, Bilateral)
Joint Replacement within last 2 yrs
Skin: Basal Cell Cancer Surgery
Skin: Melanoma Surgery
Colectomy: Diverticulitis
Kidney Removed (Right, Left)
Spleen Removed
Heart Disease (HBP, LBP)
Hysterectomy
Ovaries Removed
Ovaries Removed: Cyst
None

Other: _____

_____

Name: _____ Date:_____

Skin Disease History: (please circle all that apply)

Basal Cell Skin Cancer	Dry Skin	Eczema
Blistering Sunburns	Flaking or Itchy Scalp	Psoriasis
Precancerous Moles	Hay Fever/Allergies	Melanoma
Squamous Cell Skin Cancer	**None**	

Other: _____

_____

Social History: (please circle all that apply)

Cigarette Smoking:
- Never smoked
- Quit: former smoker
- Smoke less than daily
- Smoke daily

Illicit Drug Use:
- None
- Drug Use
- IV Drug Use

Safety:
- I feel safe at home
- I do not feel safe at home

Occupation (former occupation): _____

Medications:

(Please enter all current medications or attach a current medication list)

	Name	Strength	Dosage	Frequency
1.				
2.				
3.				
4.				
5.				
6.				

Name: _____ Date: _____

Allergies: (Please enter all allergies)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Alerts: Are you currently experiencing any of the following?

Alert	Yes	No
Blood Thinners		
Defibrillator/Pacemaker		
Artificial or damaged heart valve		
Artificial joints within the past two years		
MRSA		

Other:_____