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):**

Medication	**Dose**	**Frequency**

Is there any medication to which you are truly allergic? ______________________________
Do you have seasonal allergies to pollen? ______________________________
Medical History:

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

Other (explain) ______________________________

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 ____
Fever	Yes ____	No ____
Muscle pain	Yes ____	No ____
Joint pain	Yes ____	No ____
Asthma / hay fever	Yes ____	No ____
Trouble with ears, nose, mouth or throat	Yes ____	No ____
Diarrhea	Yes ____	No ____
Burning with urination	Yes ____	No ____
Cold sores	Yes ____	No ____
Abnormal scarring	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