Patient name:	DOB:	Today's Date:
Address:	City:	State: Zip Code:
Phone:	Social Security:	PCP:
Preferred Language:	Ethnicity:	Race:
Marital Status:	Height:	Weight:
Emergency Contact:	Relationship:	Phone:
Email Address:		
Preferred Pharmacy:	Phone:	Address:

Select any of the following medical conditions that you currently have or have had:

□Anxiety	□Colon Cancer	□Hearing Loss	□Leukemia
□Arthritis	□COPD	□ Hepatitis	□Lung Cancer
□Asthma	□ Coronary Artery Disease	□ High Blood Pressure	□Lymphoma
□Atrial Fibrillation	□Depression	□ HIV/AIDs	□Prostate Cancer
□Bone Marrow Transplant	□Diabetes	□ High Cholesterol	□Radiation
□Benign Prostate Hyperplasia	□End Stage Renal Disease	□Hyperthyroidism	□Seizures
□Breast Cancer	□GERD	□Hypothyroidism	□Stroke
Other:	□None		

Select any of the following surgeries you have had:

□Appendix	□Heart: PTCA	□Ovaries: Ovarian Cancer
□Bladder (Cystectomy)	□Heart: Mechanical Valve	□Prostate: Prostate Cancer
□Breast: Biopsy Left Right Both (Circle One)	□Heart: Biological Valve	□Prostate: Prostate Biopsy
□Breast: Lumpectomy Left Right Both (Circle One)	□Heart Transplant	□Prostate: TURP
□Breast: Masectomy Left Right Both (Circle One)	□Joint Replacement: Knee Left Right Both (Circle One)	□Skin: Biopsy
□Breast Reduction	□ Joint Replacement: Hip Left Right Both (Circle One)	□Skin: Basal Cell Carcinoma
□Breast Augmentation/Implants	□Kidney Biopsy	□Skin: Squamous Cell Carcinoma
□Colon: Cancer Resection	□Kidney- Nephrectomy	□Skin: Melanoma
□Colon: Diverticulitis	□Kidney Stone Removal	□Spleen
□Colon: Inflammatory Bowel Disease	□Kidney Transplant	□Testicles
□Gallbladder	□Ovaries: Endometriosis	□Uterus: Fibroids
□Heart: Coronary Artery Bypass	□Ovaries: Ovarian Cyst	□Uterus: Uterine Cancer
Other:	□None	

Select any of the following skin conditions you currently have or have had:

□Acne	□Dry Skin	□Poison Ivy
□Actinic Keratosis	□Eczema	□Precancerous Moles/Dysplastic Nevus
□Asthma	□Flaking or itchy scalp	□Psoriasis
□Basal Cell Carcinoma	□Hay Fever/Allergies	□Squamous Cell Carcinoma
□Blistering Sunburns	□Melanoma:_____	
Other:	□None	

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?

PLEASE COMPLETE BOTH SIDES OF FORM

Please list the medications you take:

Name	Dose	How Often		Name	Dose	How Often

Do you pre-medicate with antibiotics before procedures?	YES	NO	
Do you take blood thinners?	YES	NO	Name:

List any allergy to medication: _____

What type of reaction do you have? _____

Social History (over 12):

□Current every day smoker	□Current some day smoker	□ Former smoker	□Never smoker
Do you drink alcohol? □Yes □No	If yes: □less than 1 drink per day	□1-2 drinks per day	□ more than 3 drinks per day
How many times in the past year have you had 5 or more drinks in a day? _____			

Vaccination Status; Have you received the following:

□ Flu Vaccine When: _____	□ Shingles vaccine (over 50)	□ Pneumonia vaccine (over 65)	□Age 9-13: A series of 3 HPV (Human Papillomavirus)

Advance Care (over 65):

Do you have a health proxy in the event you are unable to make your own medical decision? □Yes □No

Designee's name: _____ Designee's phone number: _____

Do you have a living will? □Yes □No Which statement reflects your wishes on advanced care recommendations?

□ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

□ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life.

□ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Family History:

	Which family member?		Which family member?
□Arthritis		□End Stage Renal Disease	
□Asthma		□ Hepatitis	
□Cancer		□ High Blood Pressure	
□ Coronary Artery Disease		□Seizures	
□COPD		□Skin cancer	
□Depression		□Stroke	
□Diabetes		Other:	

Patient Signature: _____ Date: _____

PLEASE COMPLETE BOTH SIDES OF FORM