



Date: \_\_\_\_\_

LEGAL Name: \_\_\_\_\_ Soc. Sec# \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Email Address: \_\_\_\_\_

Spouse or Parent / Guardian : \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City / State: \_\_\_\_\_ Zip: \_\_\_\_\_

Seasonal Address: \_\_\_\_\_ City / State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnic Group: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

**Friend or relative not living with you that we may contact in case of emergency (REQUIRED):**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Referring Physician : \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Regular Physician : \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

**Preferred Pharmacy**

Name: \_\_\_\_\_ Street / City: \_\_\_\_\_

**WE WILL NEED TO COPY ALL OF YOUR CURRENT INSURANCE CARDS FOR OUR RECORDS**

**Policy Holder's Insurance Information is REQUIRED to file to Insurance**

**Primary Insurance Company**

Insurance Co Name: \_\_\_\_\_ ID # : \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Soc. Sec #: \_\_\_\_\_

Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

**Secondary Insurance Company**

Insurance Co Name: \_\_\_\_\_ ID # : \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Soc. Sec #: \_\_\_\_\_

Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Past Medical History

Select any of the following medical conditions you currently have:

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- Bone Marrow Transplant
- BPH
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression

- Diabetes
- End Stage Renal Disease
- GERD
- Hearing Loss
- Hepatitis
- Hypertension
- HIV / AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Leukemia

- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- NONE
- Other

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## Past Surgical History

Have you had any surgeries on the following organs?

- Appendix (Appendectomy)
- Bladder (Cystectomy)
- Breast: Breast Biopsy
- Breast: Lumpectomy (Right, Left, Bilateral)
- Breast: Mastectomy (Right, Left, Bilateral)
- Colon (Colectomy): Colon Cancer Resection
- Colon (Colectomy): Diverticulitis
- Colon (Colectomy): Inflammatory Bowel Disease
- Colon: Colostomy
- Gallbladder (Cholecystectomy)
- Heart: Coronary Artery Bypass Surgery
- Heart: Heart Transplant
- Heart: Mechanical Valve Replacement
- Heart: PTCA
- Joint Replacement: Hip (Right, Left, Bilateral)
- Joint Replacement: Knee (Right, Left, Bilateral)
- Kidney: Kidney Biopsy
- Kidney: Kidney Stone Removal
- Kidney: Kidney Transplant
- Kidney: Nephrectomy
- Liver: Hepatectomy

- Liver: Liver Transplant
- Live: Shunt
- Ovaries (Oophorectomy): Endometriosis
- Ovaries (Oophorectomy): Ovarian Cancer
- Ovaries (Oophorectomy): Ovarian Cyst
- Ovaries: Tubal Ligation
- Pancreas: Pancreatectomy
- Postate (Prostatectomy): Prostate Biopsy
- Prostate (Prostatectomy): Prostate Cancer
- Prostate (Prostatectomy): TURP
- Rectum: APR
- Rectum: Low Anterior Resection
- Skin: Basal Cell Carcinoma
- Skin: Melanoma
- Skin: Skin Biopsy
- Skin: Squamous Cell Carcinoma
  
- Spleen (Splenectomy)
- Testicles (Orchiectomy)
- Uterus (Hysterectomy): Fibroids

Uterus (Hysterectomy): Cervical Cancer

NONE  
 Other

### Skin Disease History

Have you had any of the following?

- Acne
- Actinic Keratoses
- Asthma
- Basal Cell Skin Cancer
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking or Itchy Scalp
- Have Fever / Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Skin Cancer
- NONE
- Other

Do you have a family history of Melanoma?

Yes  No

If yes, which relative?

- Mother
- Father
- Sister
- Brother
- Daughter
- Son
- Uncle
- Aunt
- Nephew
- Niece
- Grandmother
- Grandfather
- Grandson
- Granddaughter
- Other

Do you wear Sunscreen?

Yes  No

If yes, what SPF? \_\_\_\_\_

Do you tan in a tanning salon?

Yes  No

### Medications

List all current medications:

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## Allergies

List all allergies and reactions if known:

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## Social History

### Smoking Status (please choose one):

- Current everyday smoker
- Current someday smoker
- Former smoker
- Never smoker
- Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy \_\_\_\_\_

Quit Smoking:

- mm/dd/yyyy \_\_\_\_\_

Number of Packs Per Day: \_\_\_\_\_

Total Years Smoking: \_\_\_\_\_

### Alcohol Intake (please choose one):

- None
- 1 or less per day
- 1-2 per day
- 3 or more per day

### Occupation and Workplace:

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### Place of Residence:

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## Family History

Please include only first-degree relatives:

### Driving Status:

- Drives in the Daytime
- Drives at Night

### How often do you exercise?

- Unspecified
- Several times a day
- Once a day
- A few times a week
- A few times a month
- Never
- Other \_\_\_\_\_

### What is your caffeine use?

- Unspecified
- Several times a day
- Once a day
- A few times a week
- A few times a month
- Never
- Other \_\_\_\_\_

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## Review of Systems

Do you have any of the following?

- Problems with Bleeding
- Problems with Healing
- Problems with Scarring (hypertrophic or keloid)
- Rash
- Immunosuppression
- Hay Fever
- Allergy to Topical Antibiotic Ointment
- Chest Pain
- Fever or Chills
- Night Sweats
- Unintentional Weight Loss
- Sore Throat
- MRSA
- Blurry Vision
- Abdominal Pain
- Thyroid Problems
- Bloody Stool
- Joint Aches
- Muscle Weakness
- Neck Stiffness
- Headaches
- Seizures
- Cough
- Shortness of breath
- Wheezing
- Anxiety
- Depression
- Changing Mole
- Blood Thinners

## Alerts

Do you have any of the following?

- Allergic to Adhesive
- Allergic to Lidocaine
- Artificial Heart Valve
- Artificial Joints within the past two years
- Premedication Prior to Procedures