PATIENT HISTORY SHEET

Name:_____ Birthdate_____

Who is your primary care doctor (GP)?_____
Were you referred for this visit? (Please circle) YES NO If so, by whom?_____
I give consent to retrieve my medications through my pharmacy benefit providers (please circle) YES NO
What pharmacy do you use and location?_____
Are you taking aspirin, Coumadin/ warfarin or any other blood thinners? (Please circle) YES NO
If yes which one and what is your dosage?_____
Medications: or please supply a current list

Medication	Dosage	Frequency

Do you have any allergies to any medications?_____
Do you have seasonal allergies to pollen? (Please circle) YES NO
Medical History:

Accutane use	Yes____No____	Diabetes	Yes___No___
Anemia	Yes____No____	High blood pressure	Yes____No____
Arrhythmia-Atrial fib	Yes____No____	High cholesterol	Yes____No____
(Or other irregular heart beat)		Macular degeneration	Yes____No____
Arthritis of any kind	Yes____No____	Melanoma of the skin	Yes____No____
Asthma	Yes____No____	Neurologic Disease	
Cancer of any organ, like breast or lung	Yes____No____	(Parkinson's, epilepsy)	Yes____No____
Cancer of skin	Yes____No____	Tanning bed use(ever)?	Yes____No____
Connective tissue disease,ie lupus	Yes____No____	Thyroid Disease	Yes____No____
C.O.P.D	Yes____No____	Cavities under 18_____year	

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	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	Yes____No____	Trouble with ears,nose, mouth or throat	Yes___No___
Weight gain	Yes____No____	Diarrhea	Yes___No___
Fever	Yes____No____	Burning with urination	Yes___No___
Muscle pain	Yes____No____	Cold sores	Yes___No___
Joint pain	Yes____No____	Abnormal scarring	Yes___No___
Asthma/hay fever	Yes____No____	Blistering sunburns (ever?)	Yes___No___

If yes, please explain:_____

All Past Surgeries:_____
_____
Smoking: Cigarette smoking (please circle) NEVER SMOKED FORMER SMOKER SMOKING NOW
Alcohol Use: Do you drink at all? (please circle) YES NO If yes, in the past year-in one sitting/day-
do you have more than 4 drinks if female or 5 drinks if male? YES NO

Immunizations:
Flu vaccine with the past year? (please circle) YES NO If yes, when?_____
Pneumonia vaccine ever? YES NO If yes, when?_____
Have you been tested for tuberculosis, either by blood test or skin test (PPD)? YES NO