PERSONAL MEDICAL INFORMATION

PATIENT NAME / DATE OF BIRTH ______________________________ ______________________________

PREFERRED PHARMACY *(Name, City, Phone)* ______________________ ______________________________

CURRENT MEDICATIONS *(May also Provide a list / If NONE, please write NONE)*

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

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PAST MEDICAL HISTORY *(please circle)*

Anxiety	Arthritis	Asthma	Atrial Fib	BPH	Breast Ca	Colon Ca
COPD	CAD / MI	Depression	Diabetes	Kidney Disease	GERD	Hearing Loss
Hepatitis	Hypertension	HIV/AIDS	Thyroid Disease	Leukemia	Lung Ca	Lymphoma
Prostate Ca	Radiation Tx	Seizures	Stroke	Pneumonia Vax	Flu Vax	

Do you have an *Advanced Directive (Living Will)*? Yes No

If YES, does anyone make medical decisions on your behalf? Yes No

Medical Decision Maker Name: ________________________________ Phone: __________________________

PAST SURGICAL HISTORY

Organ Transplant (Which organ/date): ____

Implantable Devices (Artificial Joints / Artificial Heart Valves / Pacemakers / Defibrillators) please include date(s):

______________________________ ______________________________ ______________________________

Please list any other major surgeries: ______________________________ ______________________________

______________________________ ______________________________ ______________________________

SKIN DISEASE HISTORY (please circle)

Acne Actinic Keratosis Dry Skin Eczema Psoriasis Flaking/Itching Scalp

Basal Cell Carcinoma (Body Location(s)/When) ____

Squamous Cell Carcinoma (Body Location(s)/When) ____

Melanoma (Body Location(s)/When) ____

Family History of skin cancer (Which kind/Family member) ____

ALLERGIES (please circle): None Iodine/Seafood Latex Adhesives X-ray/IVP dye Metal/Nickel

Medication Allergies (please list): ______________________________ ______________________________

______________________________ ______________________________ ______________________________

SOCIAL HISTORY (please circle)

Do you smoke?	No	Former Smoker	Yes	If yes, How many cigarettes per day ____________
Alcohol Use?	None	Socially	2-3 drinks a day	4 or more drinks per day
Tanning bed use?	Never	Past User	Current User	