PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.
IF SOMETHING DOES NOT APPLY, PLEASE STATE "NA" DO NOT LEAVE BLANK

Patient Demographic Information:

First Name: _____ Middle: _____Last:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone Numbers: Home: _____ Work: _____ Cell:_____

Select Preferred Contact Method: ☐ **Home** ☐ **Work** ☐ **Cell**

Email: _____ SSN: _____ - _____ -_____ DOB: _____ / _____ / _____

Marital Status- ☐ Single ☐ Married (Spouse: _____) ☐ Widowed ☐ Divorced

Race _____ **Ethnicity** _____ **Language** _____

Emergency Contact- Name:_____ Phone #:_____ Relationship: _____

Referring Physician: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

Preferred Pharmacy: _____ Phone Number: _____

Pharmacy Address:_____ City: _____ State:_____ Zip: _____

Employment Information:

☐ **Full Time** ☐ **Part Time** ☐ **Retired** ☐ **Student** ☐ **Other** ☐ **Unemployed**

Occupation: _____ Company or School: _____

Phone Number: _____ Address: _____

City: _____ State: _____ Zip: _____

THIS FORM IS FRONT & BACK 

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.
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Medical History

★What is your reason for visit? _____

Patient's Past Medical History: ☑ **All that apply**

(*If NONE of the list applies to you, please* ☑ *"No Pertinent Past Medical History")*

	Details
☐ **No Pertinent Past Medical History**	
☐ Asthma	
☐ Bleeding Disorder/Clotting	
☐ Breast Cancer	
☐ Cancer	
☐ Cardiac Stents	
☐ Chest Pain / Tightness	
☐ Diabetes	
☐ Heart Disease	
☐ Heart Murmur	
☐ Hepatitis	
☐ High Blood Pressure	
☐ Other	
☐ Skin Disease	
☐ Stroke	
☐ Thyroid Disorder	
☐ Tuberculosis	
☐ Ulcers	

Does the patient have any of the following?

☐ Pacemaker ☐ Defibrillator ☐ Hip Replacement
☐ Knee Replacement ☐ Shoulder Replacement ☐ DOES NOT APPLY TO ME

Skin History (Please Check What Applies)

☐ NO SIGNIFICANT HISTORY ☐ Actinic Keratosis ☐ Basal Cell Carcinoma
☐ Eczema ☐ Malignant Melanoma ☐ Other Suspicious Lesion
☐ Psoriasis ☐ Squamous Cell Carcinoma ☐ Urticaria

THIS FORM IS FRONT & BACK

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Past Surgeries: (*If none, please state NONE)*

Surgery/Hospitalization	Date	Physician	Anesthesia Complications?	Notes

Patient's Family History:

(*If **nothing** on the list applies, please ☑ "No Relevant Family History")*

PLEASE ONLY STATE: ***Mother, Father, Brother, Sister, Children & Grandparents (Also, indicate Maternal or Paternal)***

	Afflicted Family Member
☐ **No Relevant Family History**	
☐ Unknown – Adopted	
☐ Abnormal Bleeding	
☐ Abnormal Clotting	
☐ Breast Cancer	
☐ Cancer	
☐ Diabetes	
☐ High Blood Pressure	
☐ Premature Coronary Heart Disease	
☐ Von Willebrand	

Allergies: (*if none, please state NONE)*

Allergy	Reaction

THIS FORM IS FRONT & BACK 

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.
IF SOMETHING DOES NOT APPLY, PLEASE STATE "NA" DO NOT LEAVE BLANK

Current Oral & Topical Medications: (*If none, please state NONE)*

Medication	Dosage	Taken How Often	Route Taken (Oral, Topical, Injection?)	Prescribing Doctor

Patient's Social History: (Must choose at least one answer in each category)

Alcohol Use

- ☐ Denies alcohol use
- ☐ Alcohol use socially
- ☐ Alcohol use daily
- ☐ History of alcoholism

Recreational Drug Use

- ☐ Denies recreational drug use
- ☐ Admits recreational drug use
- ☐ History of drug abuse

STD Status

- ☐ Denies STD history
- ☐ Admits STD history

Smoking Status

- ☐ Current every day smoker – **Year Started:** _____
- ☐ Current some day smoker – **Year Started:** _____
- ☐ Never Smoked
- ☐ Former Smoker:
  Year Started: _____
  Year Quit: _____

Female Questions:

Age of first period? _____

Number of pregnancies? _____

Number of children? _____

Have you ever breast fed? _____

Date of last mammogram? _____

Height: _____Inches **Weight: _____Pounds**

Height Cheat Sheet

4' = 48 in	5' = 60 in
4'6" = 54 in	5' 6" = 66 in
5' = 60 in	6' = 72 in

_____
Print Name of Patient

_____ _____
Signature of Patient/Legal Guardian Date