

**PATIENT MEDICAL HISTORY**

**DATE:** \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_ **BIRTHDATE:** \_\_\_\_\_

**PRIMARY CARE MD:** \_\_\_\_\_ **REFERRING MD:** \_\_\_\_\_

**Reason for today's visit?** \_\_\_\_\_

**■ PAST MEDICAL HISTORY**

- Anxiety       Diabetes       Lung Cancer       Arthritis       Kidney Disease
- Lymphoma       Asthma       Heartburn/Reflux       Prostate CA       Atrial Fibrillation
- Hearing Loss       Radiation Treatment       Bleeding Disorder       Hepatitis       Seizures
- Breast Cancer       High Blood Pressure       Stroke       Colon Cancer       HIV/AIDS
- COPD       HSV/Cold Sores       High Cholesterol       Depression       Thyroid Problems

**SKIN DISEASE:**     Melanoma       Basal/Squamous Cell Cancer       Precancerous/Atypical Moles

Other: \_\_\_\_\_

**PAST SURGICAL HISTORY:** \_\_\_\_\_

**■ FAMILY HISTORY**

- Melanoma       Abnormal Moles       Basal/Squamous Cell Cancer       Breast Cancer

Other: \_\_\_\_\_

**■ REVIEW OF SYSTEMS**

- Fever or Chills       Diarrhea/Constipation       Night Sweats       Joint Pain       Fatigue
- Rash or Itchy Skin       Unexplained Weight Loss       Hives       Swollen lymph Nodes       Easy Bruising
- Leg Swelling       Blurry Vision       Blood Clots       Chronic Cough       Abdominal Pain
- Shortness of Breath       Immunosuppression       Chest Pain       Headaches/Dizzy
- Depression       Nausea/Vomiting

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**WOMEN ONLY:**     Pregnant       Nursing       Breast Biopsy      Date of last Mammogram: \_\_\_\_\_

**MEDICATION:** (prescribed and over the counter) \_\_\_\_\_

**BLOOD THINNERS:**     Aspirin       Ibuprofen       Coumadin       Plavix       Other: \_\_\_\_\_

**Are you ALLERGIC to any medications?**     Yes     No (list) \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Hobbies:** \_\_\_\_\_

**Smoking:**       Current - Amount: \_\_\_\_\_       Never       Former - Quit \_\_\_\_\_

**Alcohol Use:**     None       Less than 1/day       1-2 day       3 or more/day

\_\_\_\_\_  
**Signature of Patient/Guardian**

\_\_\_\_\_  
**Date**