Patient History Form

Please Print

Today's Date: _____

Name: _____ Date of Birth: _____

Primary Care Physician _____ Referring Physician _____

Please check "yes" or "no" for the following

Past Medical History: Have you ever had any of the following?

Pace Maker/Defibrillator Yes☐ No☐
HIV/AIDS Yes☐ No☐
Blood transfusion Yes☐ No☐
Bleeding tendencies Yes☐ No☐
Artificial joint Yes☐ No☐ Year☐☐
Leukemia/ Lymphoma Yes☐ No☐
Chemical/radiation exposure Yes☐ No☐
Hepatitis Yes☐ No☐ A/B/C
Diabetes Yes☐ No☐
Organ Transplant Yes☐ No☐
Artificial heart valve Yes☐ No☐
Influenza Vaccine Yes☐ No☐ Year☐☐
Pneumococcal Vaccine Yes☐ No☐ Year☐☐
Current use of sunscreen: Daily☐ Occasionally☐ None☐
Tanning Bed use: Current☐ Previous☐ Never☐

Skin History: Have you ever had any of the following?

Skin cancer Yes☐ No☐ Type _____
Melanoma Yes☐ No☐
Pre cancerous lesions (AK's) Yes☐ No☐
Family history of Melanoma (parent, sibling or child) _____

Bring a complete list of all medications to your appointment; include the name, strength & dosage.
Bring a complete list of all medication allergies including reaction to each.

Alcohol-oz - Yes☐ No☐ Quit☐ **If yes:** Number of drinks per day_____
Smoking-Cig-Yes☐ No☐ Quit☐ **If yes**: Number of packs per day_____

Is there any other medical history relevant to today's procedure?

_____

To the best of my knowledge, the questions on this form have been answered accurately.
I understand that providing incorrect information can be dangerous to my health.
It is my responsibility to inform my physician of any changes in my medical status.

_____ _____

Signature of Patient (or Guardian) **Date**