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__
Pneumococcal Vaccine Yes__ No__ Year___
Current use of sunscreen: Daily__ Occasionally__ None__
Tanning Bed use: Current__ Previous__ Never__

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___

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?
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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**