

# Medical History Form

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Preferred Pharmacy

Name: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Phone Number: \_\_\_\_\_

Referring Physician \_\_\_\_\_

City or Zip Code: \_\_\_\_\_

Do we have permission to import medication from your pharmacy  Yes  No

## Past Medical History

Select any of the following medical conditions you currently have:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> End Stage Renal Disease    | <input type="checkbox"/> Lymphoma            |
| <input type="checkbox"/> Arthritis/Joint problems | <input type="checkbox"/> GERD                       | <input type="checkbox"/> Prostate Cancer     |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Hearing Loss               | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> (AF) Irregular Heartbeat | <input type="checkbox"/> Hepatitis A/B/C            | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Bone Marrow Transplant   | <input type="checkbox"/> High blood pressure        | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> BPH (Enlarged prostate)  | <input type="checkbox"/> HIV/AIDS                   | <input type="checkbox"/> Other               |
| <input type="checkbox"/> Breast Cancer            | <input type="checkbox"/> High cholesterol           | _____  |
| <input type="checkbox"/> Colon Cancer             | <input type="checkbox"/> Overactive Thyroid (Hyper) | _____  |
| <input type="checkbox"/> COPD                     | <input type="checkbox"/> Low Thyroid (Hypo)         | _____  |
| <input type="checkbox"/> Coronary Artery Disease  | <input type="checkbox"/> Leukemia                   | <input type="checkbox"/> NONE                |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Lung Cancer                |  |
| <input type="checkbox"/> Diabetes                 |   |  |

## Past Surgical History

Have you had any surgeries on the following organs (Please circle appropriate location or condition)

- |   |  |
|---|--|
| <input type="checkbox"/> Appendix                                 | <input type="checkbox"/> Colon: Colostomy                                    |
| <input type="checkbox"/> Bladder                                  | <input type="checkbox"/> Gallbladder   |
| <input type="checkbox"/> Breast Biopsy                            | <input type="checkbox"/> Heart Valve Replacement (Tissue or Mechanical)      |
| <input type="checkbox"/> Breast: Lumpectomy (Both, Left or Right) | <input type="checkbox"/> Heart Bypass  |
| <input type="checkbox"/> Breast: Mastectomy (Both, Left or Right) | <input type="checkbox"/> Heart Transplant                                    |
| <input type="checkbox"/> Colon: Cancer Resection                  | <input type="checkbox"/> PTCA (Angioplasty or Stent)                         |
| <input type="checkbox"/> Colon: Diverticulitis                    | <input type="checkbox"/> Joint Replacement – Knee: Right, Left or Both Sides |
| <input type="checkbox"/> Colon: Inflammatory Bowel Disease        | <input type="checkbox"/> Joint Replacement – Hip: Right, Left or Both Sides  |

# Medical History Form

- Kidney: Biopsy, Stone Removal, Transplant, Removal
- Liver: Partial removal, transplant or shunt
- Ovaries removal: Endometriosis, Cancer or Cysts
- Ovaries: Tubal Ligation
- Pancreas: Partial removal
- Prostate: Biopsy, Cancer or TURP
- Rectum: APR- Resection of the Rectum

- Skin: Basal Cell, Squamous Cell, Melanoma
  - Spleen (Removal)
  - Testicles (Removal)
  - Uterus: (Removal) Fibroids, Uterine or Cervical Cancer
  - Other
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Females Only:**

Are you currently pregnant?  Yes  No  
 LMP: \_\_\_\_\_

**Skin Disease History**

**Have you had any of the following?**

- Acne
  - Actinic Keratoses
  - Basal Cell Skin Cancer
  - Blistering Sunburns
  - Eczema
  - Flaking or Itchy Scalp
  - Hay Fever / Allergies
  - Melanoma Skin Cancer
  - Poison Ivy
  - Precancerous Moles
  - Psoriasis
  - Squamous Cell Skin Cancer
  - Other
- \_\_\_\_\_
- NONE

**Do you wear Sunscreen?**

Yes  No  
 If yes, what SPF? \_\_\_\_\_

**Do you tan in a tanning salon?**

Yes  No

**Family History**

**Do you have a family history of Melanoma?**  Yes  No  
 If yes, which family member(s)?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Medical History Form

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## Medications

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List all current medications: (Please include dosage and strength if known)

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## Allergies

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List all allergies and reactions if known:

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## Social History

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### Smoking Status (please choose one):

- Current every day smoker
- Current someday smoker
- Former smoker
- Never smoker
- Unknown if ever smoked

Number of Packs Per Day: \_\_\_\_\_

Total Years Smoking: \_\_\_\_\_

### Alcohol Intake (please choose one):

- None
- 1 or less per day
- 1-2 per day
- 3 or more per day