Patient Medical History

Name:_____ **DOB:** _____ **Today's Date:** _____

Medical History
(Please check the following that apply)

Skin Cancer:
- o Basal cell
  *Where:*_____
  *When:*_____
- o Squamous cell
  *Where:*_____
  *When:*_____
- o Melanoma
  *Where:*_____
  *When:*_____
- o Abnormal Moles
  *Where:*_____
  *When:*_____

- o Eczema
- o Psoriasis
- o Hives
- o Hay fever /allergies/asthma
- o Transplant of kidney or other organ
- o Autoimmune disease (i.e. Lupus)
- o Hepatitis/ liver disease
- o Kidney disease
- o Arthritis
- o Diabetes
- o Bleeding Disorders
- o Stroke
- o Cancer
- o Fainting/seizures
- o Headaches
- o Heart disease/valve disease
- o Heart murmur/rheumatic fever
- o Ulcers/stomach/bowel disease
- o Vision problems
- o Thyroid disease
- o Tuberculosis
- o Previous surgeries:_____
- o Other:_____
  _____

Family History
Do you have any family history of skin cancer? YES NO
If so, what type of skin cancer?_____

Other
Do you have any of the following?

Artificial joints?	YES	NO
Artificial heart valves?	YES	NO
Latex allergy?	YES	NO
Pacemaker?	YES	NO
Hepatitis?	YES	NO
HIV/AIDS?	YES	NO

The above information is correct to the best of my knowledge.

Signature:_____ Date:_____

Parent/guardian for minors:_____ Date:_____

Patient Medical History

Name:_____ **DOB:** _____ **Today's Date:** _____

Who is your Primary care physician? _____

Referring Provider / Friend? _____

Are You:

Pregnant?	YES	NO	Nursing?	YES	NO
Taking Aspirin?	YES	NO	Taking Blood Thinners?	YES	NO

Do You:

Take antibiotics prior to dental work? YES NO

Tobacco Use? EVERYDAY SOMEDAY NEVER FORMER

Alcohol Use? YES NO # OF DRINKS/DAY: _____

How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? _____

Influenza Vaccine

Check the one that best fits:

- ☐ Received a flu vaccine this flu season.
- ☐ Did not receive a flu vaccine this flu season because of medical reasons.
- ☐ Did not receive a flu vaccine this flu season because I don't want one.
- ☐ Did not receive a flu vaccine this flu season.

Pneumococcal Vaccine

Check the one that best fits:

- ☐ Received a pneumococcal vaccine.
- ☐ Did not receive a pneumococcal vaccine.

Advanced Directives

Advanced directives are designed to respect your autonomy and determine your wishes about future life-sustaining medical treatments if you are unable to indicate your wishes. Key interventions and treatment decisions are: resuscitation procedures such as cardiopulmonary resuscitation (CPR) and mechanical respiration (breathing tube).

Which statement(s) best reflect your wishes on advanced care recommendations?

- ☐ I want full cardiopulmonary resuscitation efforts to be made (Full Code)
- ☐ I do not wish to have a breathing tube, even if it is necessary to save my life (Do not intubate).
- ☐ If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life (Do not resuscitate).
- ☐ I have a living will.
- ☐ I have a health care proxy whose name is _____ Contact # _____

The above information is correct to the best of my knowledge.

Signature:_____ Date:_____

Parent/guardian for minors:_____ Date:_____