Patient Demographic Information

First Name: ______________________ Middle: ________________ Last: ______________________________

Address: _____________________________________ City: ____________________ State: ______ Zip: ______

Phone Numbers: Home: __________________ Work: ____________________ Cell: __________________

Select Preferred Contact Method: ☐ **Home** ☐ **Work** ☐ **Cell**

Email: _____________________________ SSN: ________ - _______ - _________ DOB: _____ / _____ / _____

Marital Status ☐ Single ☐ Married (Spouse: ______________________________) ☐ Widowed ☐ Divorced

Race _____________________ **Ethnicity** _____________________ **Language** ___________________

Emergency Contact Name: ____________________________ Relationship: _____________________________

Phone #: ____________________ ☐ **Home** ☐ **Work** ☐ **Cell** Alt #: ____________________ ☐ **Home** ☐ **Work** ☐ **Cell**

Referring Physician: __________________________________ Phone Number: ________________________

Primary Care Physician: _______________________________ Phone Number: ________________________

Preferred Pharmacy: __________________________________ Phone Number: ________________________

Pharmacy Address: ___________________________ City: ____________________ State: _______ Zip: _________

Employment Information:

☐ **Full Time**	☐ **Part Time**	☐ **Retired**	☐ **Student**	☐**Other**	☐ **Unemployed**

Occupation: ____________________________ Company or School: __________________________________

Phone Number: ______________________ Address: ____

City: _______________________________ State: ______________________ Zip: ____________________

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.
IF SOMETHING DOES NOT APPLY, PLEASE STATE "NA" DO NOT LEAVE BLANK

Patient Name: ______________________________ **Date of Birth:**____________

Reason for today's visit: ____

Patient's Past Medical History - ☑ All that apply

(If NONE of the list applies to you, please ☑ "No Pertinent Past Medical History")

	Details
☐ **No Pertinent Past Medical History**	
☐ Asthma	
☐ Bleeding Disorder/Clotting	
☐ Breast Cancer	
☐ Cancer	
☐ Cardiac Stents	
☐ Chest Pain / Tightness	
☐ Diabetes	
☐ Heart Disease	
☐ Heart Murmur	
☐ Hepatitis	
☐ High Blood Pressure	
☐ Other	
☐ Skin Disease	
☐ Stroke	
☐ Thyroid Disorder	
☐ Tuberculosis	
☐ Ulcers	

Does the patient have any of the following?

☐ **Pacemaker** ☐ **Defibrillator** ☐ **Hip Replacement**
☐ **Knee Replacement** ☐ **Shoulder Replacement** ☐ **DOES NOT APPLY TO ME**

Skin History (Please Check What Applies)

☐ **NO SIGNIFICANT HISTORY** ☐ **Actinic Keratosis** ☐ **Basal Cell Carcinoma**
☐ **Eczema** ☐ **Malignant Melanoma** ☐ **Other Suspicious Lesion**
☐ **Psoriasis** ☐ **Squamous Cell Carcinoma** ☐ **Urticaria**

THIS FORM IS FRONT & BACK

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.
IF SOMETHING DOES NOT APPLY, PLEASE STATE "NA" DO NOT LEAVE BLANK

Past Surgeries: *(If none, please state NONE)*

Surgery or Hospitalization	Date	Physician	Anesthesia Complications?	Notes

Patient's Family History:
PLEASE ONLY STATE: ***Mother, Father, Brother, Sister & Children***

Condition	Afflicted Family Member
☐ **No Relevant Family History**	
☐ Unknown – Adopted	
☐ Abnormal Bleeding	
☐ Abnormal Clotting	
☐ Breast Cancer	
☐ Cancer	
☐ Diabetes	
☐ High Blood Pressure	
☐ Premature Coronary Heart Disease	
☐ Von Willebrand	
☐ Other	

Allergies: *(if none, please state NONE)*

Allergy	Reaction

THIS FORM IS FRONT & BACK

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.
IF SOMETHING DOES NOT APPLY, PLEASE STATE "NA" DO NOT LEAVE BLANK

Current Oral & Topical Medications: (*If none, please state NONE*)

Medication Name	Dosage	Taken How Often?	Route Taken (Oral, Topical, Injection?)	Prescribing Doctor

Patient's Social History:

(Must choose at least **one** answer in each category)

Alcohol Use

- ☐ Denies alcohol use
- ☐ Alcohol use socially
- ☐ Alcohol use daily
- ☐ History of alcoholism

Recreational Drug Use

- ☐ Denies drug use
- ☐ Admits drug use
- ☐ History of drug abuse

Female Questions:

Age of first period? ______________

Number of pregnancies? ______________

Number of children? ______________

Have you ever breast fed? ______________

Date of last mammogram? ______________

Height: _______ inches **Weight:** _______ lbs

Height Guide:

4' = 48 in.	**5'6" = 66 in.**
4'6" = 54 in.	**6' = 72 in.**
5' = 60 in.	**6'6" = 78 in.**

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Print Name of Patient

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Signature of Patient/Legal Guardian Date