

First name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_

Birthdate \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

**Please list the phone numbers and email where we can reach you:**

	Phone number/email	Preferred method of contact	OK to leave a message?
Cell phone		<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Home phone		<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Work phone		<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other phone		<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Email address		<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Please list any other contacts we can speak to in case of emergency or regarding your health:**

Emergency

Contact \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Phone \_\_\_\_\_

Authorized Medical

Info. Contact \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Phone \_\_\_\_\_

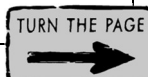
Referring physician \_\_\_\_\_ Phone \_\_\_\_\_

Primary care provider \_\_\_\_\_ Phone \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_

**Past medical history**

<input type="checkbox"/> - No Pertinent Past Medical History	<input type="checkbox"/> History of staph infection
<input type="checkbox"/> Artificial heart valve	<input type="checkbox"/> HIV
<input type="checkbox"/> Asthma or emphysema	<input type="checkbox"/> Joint problems or artificial joint
<input type="checkbox"/> Bleeding tendency	<input type="checkbox"/> Keloids or abnormal healing
<input type="checkbox"/> Blood clot	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Cancer (other than skin)	<input type="checkbox"/> Leg swelling or varicose veins
<input type="checkbox"/> Cold sores	<input type="checkbox"/> Liver disease or hepatitis
<input type="checkbox"/> Depression or anxiety	<input type="checkbox"/> Neurologic disorder
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Organ Transplant
<input type="checkbox"/> Eye or vision problems	<input type="checkbox"/> Pacemaker / Defibrillator
<input type="checkbox"/> Hay fever (seasonal allergies)	<input type="checkbox"/> Radiation Therapy
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Other History



Current medications (if none, please write none)				
	Medication Name	Dosage	# of times daily	Notes
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Allergies (if none, please write none)		
	Reaction	Notes
1		
2		
3		

	Family history	Effected family member	Notes
<input type="checkbox"/>	- No Contributing Family History		
<input type="checkbox"/>	Adopted		
<input type="checkbox"/>	Basal or squamous cell carcinoma		
<input type="checkbox"/>	Malignant Melanoma		
<input type="checkbox"/>	Atopy (Eczema, asthma, or hay fever/seasonal allergies)		
<input type="checkbox"/>	Psoriasis		
<input type="checkbox"/>	Pancreatic cancer		
<input type="checkbox"/>	Bleeding disorder or blood clots		
<input type="checkbox"/>	Other Family History		



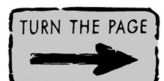
Past surgeries/hospitalizations			
	Surgery	Date	Notes
1			
2			
3			
4			
5			
6			

Ability to Heal		
1	Does your skin appear fragile, burns easily?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Do you form thick or raised scarring from a cut or burn?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Do you wax or use depilatories on your face?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Do you ever get cold sores?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Female Questions		
1	Do you have regular periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
2	When was your last menstrual period?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
3	Are you going through menopause?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
4	Are you currently pregnant or lactating?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5	During pregnancy, did you ever get hyperpigmentation or masking?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6	How many pregnancies?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
7	How many live births?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
8	Did you breast feed? If yes, how many times?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

	Cancer History	Location	Treatment
<input type="checkbox"/>	Breast Cancer		
<input type="checkbox"/>	Malignant Melanoma		
<input type="checkbox"/>	Ovarian Cancer		
<input type="checkbox"/>	Skin Cancer		
<input type="checkbox"/>	Other		

Height / Weight		
Height	Weight (lbs)	Highest Weight (lbs)



Social history		Personal Habits	
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic partner	Illegal Drugs:	<input type="checkbox"/> denies using illegal drugs <input type="checkbox"/> admits to using illegal drugs <input type="checkbox"/> admits to history of drug abuse
Occupation:		Tobacco Use:	<input type="checkbox"/> Current every day smoker <input type="checkbox"/> Current some day smoker <input type="checkbox"/> Former smoker <input type="checkbox"/> Never smoker <input type="checkbox"/> Smoker, current status unknown <input type="checkbox"/> Unknown if ever smoked <input type="checkbox"/> Heavy tobacco smoker <input type="checkbox"/> Light tobacco smoker  Date Started: _____  Date Ended: _____
Alcohol:	<input type="checkbox"/> denies alcohol use <input type="checkbox"/> admits alcohol use socially <input type="checkbox"/> admits alcohol use daily <input type="checkbox"/> admits to history of alcoholism		
STD:	<input type="checkbox"/> denies STD history <input type="checkbox"/> admits STD history <input type="checkbox"/> blood transfusion		

Allergic/Immunologic/Infectious		
1	Allergic/Immunologic/ Infectious Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Tuberculosis (TB)	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Autoimmune disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
5	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No

Implant/Device History		
1	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Breast Implants	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Other Implants	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Tissue Expander	<input type="checkbox"/> Yes <input type="checkbox"/> No
5	Joint or other replacement implant	<input type="checkbox"/> Yes <input type="checkbox"/> No
6	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No



**REVIEW OF SYSTEMS:**

Please answer the following yes/no questions to the best of your ability. Do you have any of the following conditions, illnesses or symptoms?

<b>HEMATOLOGIC/ONCOLOGIC</b>	<b>Yes</b>	<b>No</b>	<b>RESPIRATORY</b>	<b>Yes</b>	<b>No</b>
Breast Disease			Asthma		
Bleeding Tendency			Bronchitis		
Easy Bruising			Emphysema		
Anemia			Recent Chest Infection		
Sickle Cell Disease			Shortness of Breath (at rest/on exertion)		
Blood Clots in Legs			Dry Cough		
Blood Clots in Lungs			Cough with Sputum		
Radiation Therapy			Sleep Apnea		
<b>CARDIOVASCULAR</b>	<b>Yes</b>	<b>No</b>	Use a C-Pap machine?		
High Blood Pressure			<b>URINARY/REPRODUCTIVE</b>	<b>Yes</b>	<b>No</b>
Heart Attack			Kidney Disease		
Angina/Chest Pain			Urinary Disease		
Heart Bypass Surgery			Dialysis		
Pacemaker			<b>MUSCULOSKELETAL</b>	<b>Yes</b>	<b>No</b>
Heart Failure			Sciatica		
Irregular Heartbeat			Herniated Disk (neck, back)		
Do you exercise? Comments:			Arthritis		
<b>NEUROLOGICAL</b>	<b>Yes</b>	<b>No</b>	Rheumatoid Arthritis		
Stroke			Neck, Back, Arm, Leg Problems		
Seizures			Back/Neck Surgery		
Dizziness			<b>INFECTIOUS/GASTROINTESTINAL</b>	<b>Yes</b>	<b>No</b>
Headache			Jaundice		
Depression			Hepatitis		
Anxiety			Stomach Ulcers		
Bi-Polar			Hiatal Hernia		
<b>ENDOCRINE</b>	<b>Yes</b>	<b>No</b>	Heartburn		
Diabetes			HIV/AIDS		
Thyroid Disease			<b>SKIN</b>	<b>Yes</b>	<b>No</b>
Taken Steroids			Skin Cancer (Basal Cell, Squamous Cell, Melanoma)		
			Staph Infection		
			Problems with Scarring (E.g. keloids, widened, etc.)		

\_\_\_\_\_  
**Patient or legal guardian signature**

\_\_\_\_\_  
**Date**

**FOR OFFICE USE ONLY**

Reviewed by \_\_\_\_\_

Date \_\_\_\_\_