

 **NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH:\_\_\_/\_\_\_\_/\_\_\_ Medical record# \_\_\_\_\_\_\_\_**

 **Current Medication(s)**:  **Pharmacy**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Instructions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Instructions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Instructions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Instructions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Instructions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Instructions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Medication Allergies/Reactions:** (please circle *NKDA* if none) **NKDA**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**: (ex. Skin cancers, Melanoma, Diabetes, Hypertension, Breast Cancer…ect) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**65 years and older**: Have you ever had a Pneumonia Vaccination? NO YES, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**All Ages**: Have you had a Flu shot this season? NO YES, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**: (please check all that apply)

* Anxiety
* Arthritis
* Artificial joints

Location:\_\_\_\_\_\_\_\_\_\_\_

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

* Atrial fibrillation
* Bone Marrow Transplantation
* Breast Cancer
* Colon Cancer
* COPD/ Emphysema
* Coronary Artery Disease
* Depression
* Diabetes
* End Stage Renal Disease
* GERD (Acid reflux)
* Hearing Loss
* Hepatitis B, Hepatitis C
* Hypertension
* HIV/AIDS
* Hypercholesterolemia
* Hyperthyroidism/ Hypothyroidism
* Leukemia
* Lung Cancer
* Lymphoma
* Headaches
* Valve Replacement
* Pacemaker/ Defibrillator/ Implanted Cardiac Monitor
* Prostate Cancer
* Radiation Treatments
* Seizures
* Stroke
* Blood Thinners
* Problems with bleeding
* Problems with Healing
* Problems with scarring/keloids
* NONE
* OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin Disease History**: (please check all that apply)

* Acne
* Actinic Keratosis
* Basal Cell Skin Cancer
* Blistering
* Sunburns
* Dry Skin
* Eczema
* Flaking or Itchy Scalp
* Hay Fever/Allergies
* Melanoma

Location:\_\_\_\_\_\_\_\_\_\_\_\_

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

* Poison Ivy
* Precancerous Moles
* Psoriasis
* Squamous Cell Skin Cancer
* NONE
* Fever
* Chills
* Unexplained weight loss
* OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Review of Systems:** ARE YOU HAVING ANY OF THESE SYMPTOMS TODAY?

**Constitutional:**  chills fatigue fever night sweats weight loss weight gain

**Eyes:** blurred vision eye pain vision changes dry eyes

**Ear/Nose/Throat:** hearing problems E/N/T pain congestion rhinorrhea nose bleeds hoarseness dental problems

**Cardiovascular:** chest pain rapid/irregular heartbeat swelling

**Respiratory:** cough shortness of breath coughing blood

**Gastrointestinal:** abdominal pain heartburn constipation diarrhea stool changes

**Genitourinary:** painful/difficult urination genital lesions blood in urine impotence excessive urination

**Musculoskeletal:** joint pain back pain muscle pain

**Integumentary:** atypical moles dry skin bruising rashes

**Breast:** breast masses nipple discharge

**Neurological:** dizziness headaches burning/prickling sensation weakness

**Hematologic/Lymphatic:** easy bruising bleeding swollen lymph nodes

**Endocrine:** hair loss heat/cold intolerance excessive thirst excessive hunger

**Allergic/Immunologic:** allergies frequent illnesses HIV exposure hives

**Psychiatric:** anxiety depression sleep disturbances

**Past Surgical History**: (Surgery and year) **For FEMALES Only: NO/YES**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you take birth control? NO YES

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you pregnant? NO YES

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you plan on becoming pregnant? NO YES

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you breast feeding? NO YES

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have breast implants? NO YES

6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History: Circle NO/YES, explain duration**:

Do you live alone? NO YES,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you (circle one) married / divorced / widowed / dosmetic partnership

Children? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink Alcohol? NO YES,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use recreational drugs? NO YES, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use ANY type of tobacco products? NO YES, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever smoked? NO YES,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you used a tanning bed? NO YES,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_