

Patient Name: _____ Date of Birth: _____

Are you allergic to any medications? Yes No If yes, which: _____

Have you ever had a bad/allergic reaction to any of the following: (Circle)

Latex Lidocaine Epinephrine Betadine Iodine Adhesives

List all the medication/vitamins/over the counter/herbal medications you are currently taking:

Do you have, or have you ever had any of the following conditions: (Circle)

Bronchitis/Emphysema

Asthma

Shortness of Breath

Heart attack/ angina

Chest Pain

Heart murmur

Irregular heart beat

Heart Failure

Phlebitis/ blood clots

Pacemaker

Fainting with medical procedures

Hay fever

Ear/nose/sinus/throat problems

Diabetes

Thyroid condition

Kidney disease

Dialysis

Bladder problems

Gastrointestinal problems

Nausea/vomiting from antibiotics

Arthritis

Artificial joint

Convulsion/epilepsy

Coronary Artery Disease (CAD)

Chronic Obstruction Pulmonary Disease (COPD)

Other _____

Do you have high blood pressure? YES NO If yes, describe: _____

Have you had any surgical procedures? _____

Have you ever had skin cancer? YES NO If yes, describe: _____Has anyone in your family has skin cancer? YES NO If yes, describe: _____Has anyone in your family had Melanoma? YES NO If yes, describe: _____Do you have a history of any skin diseases? YES NO If yes, describe: _____Do you have problems with healing? YES NO If yes, describe: _____Do you develop keloid scars after surgery? YES NO If yes, describe: _____Do you bleed easily? YES NO If yes, describe: _____Do you drink alcohol? YES NO If yes, how often and how many drinks: _____Do you use IV drugs? YES NO If yes, which and how often: _____Do you smoke? Never Smoked Former Smoker Current every day smoker Current some days smoker Heavy tobacco smoker Light tobacco smokerHave you ever been exposed to HIV or AIDS? YES NOAre you: Single Married Separated/Divorced Widowed GLBTWomen; Are you pregnant? YES NO Due Date: _____

What is your occupation? _____

What are your hobbies? _____

Have you had sunburns in the past? YES NO If yes, estimate how many: _____If you have Diabetes, have you had a foot exam this year? YES NOIf over the age of 65; Have you had the Pneumococcal Vaccination? YES NO If yes, when: _____ Month _____ Year If no, why? Allergy or Medical reasons Declined/other reason_____
Patient/Parent/Guardian Signature_____
Date