Your main reason for today's visit: _____

CURRENT MEDICATIONS: _____

_____

_____

MEDICATION ALLERGIES: _____

Allergies to: Topical Antibiotics, Adhesives, Lidocaine, Epinephrine

Do you: Smoke: YES/NO (if yes: packs/day: _____ x _____ years) # of Children _____

Drink? _____ (if yes, ___ glass/day) **WOMEN – Are you pregnant YES/NO**

PLEASE CIRCLE THE FOLLOWING SYMPTOMS THAT YOU MAY HAVE:

*FEVER	CHILLS	NIGHT SWEATS	WEIGHT CHANGES
*BLURRY VISION	DOUBLE VISION	LIGHT SENSITIVITY	
*NOSE BLEEDS	HEARING LOSS	RINGING IN EARS	
*CHEST PAIN	MURMURS	PALPITATIONS	
*COUGH	SPUTUM	WHEEZING	SHORTNESS OF BREATH
*NAUSEA	VOMITING	ABDOMINAL PAIN	DIARRHEA
	BLOODY/BLACK STOOL	APPETITE CHANGES	
*PAINFUL URINATION	FREQUENT URINATION	BLOODY URINE	INCONTINENCE
*JOINT PAIN	MUSCLE PAIN	WEAKNESS	
*CHANGES IN MOLES	NEW MOLES	ITCHING	RASHES
*LOSS OF BALANCE	DIZZINESS	CONFUSION	HEADACHE
	NUMBNESS	SEIZURES	FAINTING
*ABNORMAL IDEATION	ANXIETY	DEPRESSION	
*ANEMIA	BLEEDING PROBLEMS	LYMPHEDEMA	

YOUR CURRENT OR PAST MEDICAL CONDITIONS/SURGERIES (please give details):

AIDS/HIV _____ HEAD/EYES/EARS/NOSE/THROAT/MOUTH_____

HEART (AS A VALVE REPLACEMENT) _____ NEUROLOGIC/PSYCHOLOGICAL DISORDERS _____

DIGESTIVE SYSTEM_____ URINARY SYSTEM _____

SKIN DISORDERS _____ REPRODUCTIVE SYSTEM _____

LUNGS _____ THYROID/DIABETES/HORMONAL PROBLEMS_____

RHEUMATOLOGY _____ DYSPLASTIC MOLES _____

CARDIOVASCULAR DISORDERS _____

ORTHOPEDIC DISORDERS (SUCH AS KNEE/HIP REPLACEMENT) _____

PROSTHESIS/IMPLANTS (PACEMAKER OR PACEMAKER/DEFIBRILLATOR) _____

CANCERS (SUCH AS SKIN CANCER, OVARIAN, THYROID, LUNG)_____

*OTHER: _____

FAMILY HISTORY	MOTHER	FATHER	SIBLINGS	CHILDREN
Asthma	_____	_____	_____	_____
Cancers	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Eczema	_____	_____	_____	_____
Hay Fever/Allergies	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____
Inflammatory Bowel (CROHN'S DISEASE/ULCERATIVE COLITIS)	_____	_____	_____	_____
Lung Disease	_____	_____	_____	_____
Lupus	_____	_____	_____	_____
Malignant Melanoma	_____	_____	_____	_____
Psoriasis	_____	_____	_____	_____

Other: _____