

[patient label]

Information Sheet

Family Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Medications: please list all medications that you are taking and what condition you are taking them for)

Name	On the appropriate line, list why you are taking this medication

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Allergies: please list all drug, anesthetic (numbing medication), tape, latex, iodine or food allergy

Name of Allergy	Briefly describe the reaction to your allergy

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Chief Complaint: (Please briefly describe why you are here today and list the names of any medications that you have tried for your complaint)

Personal Medical History: (Please answer the following questions)

If you have ever been diagnosed with skin cancer, please list the type, location and year:

Do you smoke? _____ If yes, how many pack(s) per day? _____

Do you drink? _____ If yes, how many drink(s) a day? _____ a week? _____

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Family Medical History: Please list family member (mother, father, brother, sister, cousin etc.), no names, that have the following condition: asthma, hayfever, psoriasis, eczema, dermatitis, or something similar to your present condition

Do you have a family history of Skin Cancer? _____ If yes, who and what type:

Do you have a family history of Malignant Melanoma? _____ If yes, who? _____

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(OVER)

Please circle all that apply or ever have applied to you in each system:

Cardiovascular:

Heart Attack (Myocardial infarction) Congestive Heart Failure Deep Vein Thrombosis High Blood Pressure (hypertension) High cholesterol (hyperlipidemia)
Coronary Artery Disease Chest Pain (stable or unstable) (angina) Pacemaker Defibrillator
Other: _____

Gastrointestinal:

Appendix Removed (Appendectomy) Gallbladder Removed (Cholecystectomy) Crohn's disease Diverticulitis Acid Reflux (Gastroesophageal reflux disease)
Pancreatitis Cirrhosis Ulcerative Colitis Inflammatory Bowel Disease
Hernia- abdominal, inguinal or umbilical Hepatitis A, B, C, or D Other: _____

Musculoskeletal:

Fibromyalgia Muscular Dystrophy Osteoarthritis Osteoporosis Rheumatoid Arthritis
Arthritis Other: _____

Genetic Syndrome:

Down's Autism Cystic Fibrosis Other: _____

Head, eyes, ears, nose and throat (HEENT):

Cataracts Glaucoma Deafness Retinal Detachment Other: _____

Hematologic:

Anemia Bleeding Disorder Hemophilia Hodgkin's Disease Sickle Cell Anemia
Other: _____

Genitourinary:

Kidney Stones Urinary Incontinence Kidney removed Kidney failure Enlarged Prostate
Other: _____

Neurologic:

Dementia Migraine/Headaches Parkinsons Seizure Disorder Multiple Sclerosis
Strokes (Cerebrovascular Accident) Mini-Strokes [TIA's] (Transient Ischemic Attack)
Other: _____

Pulmonary:

Asthma COPD Emphysema Pneumonia Pulmonary Embolism Sleep Apnea
Other: _____

Psychiatric:

ADD ADHD Anxiety Depression Bipolar Other: _____

Metabolic/Endocrine:

Diabetes (Type 1 or Type 2) Hyperthyroidism Hypothyroidism Other: _____

Immunologic:

HIV Sarcoidosis Lupus Other: _____

Infectious Disease:

Tuberculosis Lyme Disease Shingles (Herpes Zoster) Cold Sores (HSV-1)
Other: _____

Signature: _____ Date: _____

Initials: _____