Patient Name: ______________________

Patient Date of Birth: ________________

Date: ______________________

Can we leave a message with clinical information (such as a test result) on the telephone numbers you have given us? __________

Name of your Primary Care Provider: ________________________

Do you give us permission to access your medication list from your pharmacy? YES___ NO___

If you decline, please list your medications below. Please include strength (ex. 10mg) and dose (ex. Twice a day).

____

____

____

DO YOU SMOKE? ___YES___NO [If currently NO, Have you ever been a smoker?____YES____NO]

____

What Pharmacy do you use?

____

Please include address [street &/or town] if known:

____

Please check any of the following medical conditions that you currently have:

☐ Anxiety	☐ HIV / AIDS
☐ Arthritis	☐ Hypercholesterolemia (High Cholesterol)
☐ Asthma	☐ Hyperthyroidism
☐ Atrial Fibrillation (Irregular Heartbeat)	☐ Hypothyroidism
☐ Bone Marrow Transplantation	☐ Leukemia
☐ Coronary Artery Disease	☐ Lung Cancer
☐ Depression	☐ Lymphoma
☐ Diabetes	☐ Prostate Cancer
☐ End Stage Renal Disease	☐ Radiation Treatment
☐ Hearing Loss	☐ Seizures
☐ Hepatitis	☐ Stroke
☐ Hypertension (High Blood Pressure)	
OTHER:	
Check here if there are None ☐	

PLEASE TURN PAGE OVER…

Past Surgeries

Have you had any surgeries on the following organs?

☐ Appendix (Appendectomy)	☐ Heart : Mechanical Valve Replacement
☐ Bladder (Cystectomy)	☐ Heart : Biological Valve Replacement
☐ Breast (Cancer, Lumpectomy)	☐ Heart : Heart Transplant
☐ Breast (Cancer, Mastectomy)	☐ Skin : Skin Biopsy
☐ Colon (Colectomy) : Colon Cancer Resection	☐ Skin : Basal Cell Carcinoma
☐ Colon (Colectomy) : Diverticulitis	☐ Skin : Squamous Cell Carcinoma
☐ Colon (Colectomy) : Inflammatory Bowel Disease	☐ Skin : Melanoma
☐ Gallbladder (Cholecystectomy)	☐ Spleen (Splenectomy)
☐ Heart : Coronary Artery Bypass Surgery	☐ Testicles (Orchidectomy)
☐ Heart : PTCA	☐ Uterus (Hysterectomy) : Uterine Cancer
OTHER:	
Check here if there are None ☐	

Have you had any of the following skin conditions:

☐ Acne	☐ Hay Fever/Allergies
☐ Actinic Keratoses	☐ Melanoma
☐ Basal Cell Skin Cancer	☐ Poison Ivy
☐ Blistering Sunburns	☐ Precancerous Moles
☐ Dry Skin	☐ Psoriasis
☐ Eczema	☐ Squamous cell skin cancer
☐ Flaking or Itchy Scalp	

The following questions for use by the US government. You have the right to decline to answer them.

What is your preferred language: ☐ English ☐ Other: ____________________

Race: ________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Do you wear sunscreen?____YES ____ NO If yes, what SPF: __________

Do you tan in a tanning salon? ___ YES ____ NO

Do you have a family history of Melanoma?______YES ____NO

If yes, what relative(s)? ____

Do you have any allergies? ___ YES ____NO

If yes, please list here (specifically include Medicines, Latex or products & Food allergies):

Allergy:__________________	Allergy:__________________	Allergy:__________________
Describe Reaction:	Describe Reaction:	Describe Reaction:
☐ Anaphylaxis	☐ Anaphylaxis	☐ Anaphylaxis
☐ Angioedema (Facial Swelling)	☐ Angioedema (Facial Swelling)	☐ Angioedema (Facial Swelling)
☐ Diarrhea	☐ Diarrhea	☐ Diarrhea
☐ Fatigue	☐ Fatigue	☐ Fatigue
☐ GI upset	☐ GI upset	☐ GI upset
☐ Hives	☐ Hives	☐ Hives
☐ Liver toxicity	☐ Liver toxicity	☐ Liver toxicity

List more allergies here, the nursing staff will go over them with you:

____

____

____

Please check any of the following statements that are applicable to you:

- ☐ MVP (Mitral Valve Prolapse)
- ☐ Have a pacemaker
- ☐ Have a defibrillator
- ☐ Have an artificial heart valve
- ☐ Premedicate prior to procedures
- ☐ Have an allergy to adhesive
- ☐ Have an allergy to topical antibiotic ointments
- ☐ Take blood thinners (e.g. aspirin, Coumadin, etc.)
- ☐ Allergic to lidocaine
- ☐ Rapid heart beat with epinephrine
- ☐ Get yeast infection with antibiotics
- ☐ Have GI upset with antiobiotics

PLEASE TURN OVER & COMPLETE THE QUESTIONS ON THE BACK.

Review of Systems

Name:______________________________ Do you have…	Yes	No
problems with bleeding		
problems with scarring (hypertrophic or keloid)		
changing mole		
cough		
fever or chills		
Hay fever		
shortness of breath		
thyroid problems		

Patient Name: ______________________________ DOB: ______________

Quality Measure Questions

The foundation of the Quality Measure program is to deliver high-quality patient care. This questionnaire has been created to gather information about each patient. Using a variety of tools, our physicians will report data according to government regulations and receive valuable feedback about our practices.

1E. Have you ever had a melanoma diagnosed or treated? YES ☐ NO☐

2C. Do you smoke? YES ☐ NO☐ FORMER☐

3CE. Are there any changes to your medications since your last appointment? YES ☐ NO☐

If yes, please discuss these with the Medical Assistant so we can update your chart.

4E. Have you had an Influenza (FLU) vaccine this season? YES ☐ NO☐

65 years of age and older only:

5C. Have you ever had a Pneumonia vaccine? YES ☐ NO☐

6C. Do you have a health care proxy in the event you are unable to make your own medical decisions? YES ☐ NO☐

If yes, Designee's Name/Phone No.

____

7C. Do you have a Living Will? YES ☐ NO☐

If yes, which statement(s) best reflects your wishes on advanced care recommendations?

Do Not Intubate ☐

Do Not Resuscitate☐

Full Cardiopulmonary Resuscitation ☐