Name: ___________________________________ **Date of Birth:** ________________ **Today's Date:** __________________

Reason For Visit: ____

****Height :**	****Weight:**

Patient's Vaccination History:

****Flu Vaccine: Yes / No** **If yes, date of vaccination: Where At: Work / Other**	****Have you had your Pneumonia Vaccine in the past 5 years:** **Yes / No**

Patient Social history:

****Do you smoke: Yes / No**	**Do you use illegal street drugs? Yes / No**
Do you drink alcohol? Yes / No **If yes, daily or socially?**	**Do you have a history of STD's? Yes / No** **If yes, what type?**

Patient's Past Medical History:

Arthritis: Yes / No	Asthma: Yes / No	Bleeding Disorder: Yes / No
Breast Cancer: Yes / No	Cancer: Yes / No If yes, what type?	Cardiac Implant: Yes / No
COPD: Yes / No	Diabetes: Yes / No If yes, what type?	Eczema: Yes / No
Heart Disease: Yes / No	Hepatitis: Yes / No If yes, what type?	High Blood Pressure: Yes / No
HIV / Aids: Yes / No	Hives: Yes / No	Lung Cancer: Yes / No
Lupus: Yes / No	Mental Illness: Yes / No	MRSA: Yes / No
Physical Handicap: Yes / No	Stroke: Yes / No	Thyroid Disorder: Yes / No
Tuberculosis: Yes / No	Other:	

Female Patient's Only:

Are you pregnant? Yes / No	Are you breast feeding? Yes / No	Are you currently using Birth Control? Yes / No

Immediate Family Medical History: If you circle yes please let us know the relation to yourself

None / Unknown / Adopted	Autoimmune Disorder: Yes / No	Cancer: Yes / No If yes, what type?
Colon Cancer: Yes / No	Diabetes: Yes / No If yes, what type?	High Blood Pressure: Yes / No
Liver Disease: Yes / No	Lung Disease: Yes / No	Premature Coronary Heart Disease: Yes / No
Psoriasis: Yes / No	Skin Cancer: Yes / No If yes, what type?	Thyroid Disorder: Yes / No
Other: Yes / No		

Skin History: Please Circle all that apply

Basal Cell Carcinoma	Chicken Pox / Shingles	Eczema	Melanoma	Other:	Psoriasis	Squamous Cell Carcinoma

Please list any past surgical procedures: Any Anesthesia Complications? Yes / No

UV Exposure: Please circle all that apply

Do you use Sunblock: Yes / No	Do you use tanning booth: Yes / No Have you in the past? Yes/No

By signing this, I agree that all to information above is true and up to date: ____