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Patient's Name: _____ Age: _____ Today's Date: _____

Primary Care Doctor: _____ Referring Doctor: _____

Reason for today's visit: _____

Race: _____Ethnicity: _____Language Spoken: _____

Please complete the following medical history questions: **Hand Dominance**: □Right Handed □Left Handed

Past/Present Medical History: check box & explain

□	**CHECK IF NO PAST/PRESENT MEDICAL HISTORY**
	BELOW: Check all that apply
□	Acid Reflux
□	Anxiety
□	Arthritis
□	Asthma/Allergies
□	Autoimmune Disease
□	Bleeding disorder, anemia
□	Breast Cancer
□	Cancer
□	Chest Pain/tightness
□	Depression
□	Diabetes
□	Heart Disease
□	Heart Murmur
□	Hepatitis
□	High Blood Pressure
□	High Cholesterol
□	History of Thyroid Disease
□	Kidney or urinary tract problems
□	Liver Disease
□	Lung Disease/COPD
□	Migraines
□	Neurological or nerve problem
□	Skin Cancer
□	Skin Disease/Eczema
□	Stomach/Gastrointestinal problem
□	Other:
□	Other:
□	Other:
	******** SEE BACK SIDE ********

Social History

Do you use alcohol? □ never □ seldom □ socially
□ daily □ hx alcoholism □ other_____

Have you had a problem with pain medication addiction (past/present)? □ no □ yes, please explain
_____

Smoking status:

□ current every day smoker

□ current some day smoker

□ former smoker

□ never smoker

□ unknown if ever smoked

□ heavy tobacco smoker

□ light tobacco smoker

If smoker (Current or Past)

Allergy History

Do you have any medication allergies? No □ Yes □
If so, please list below:

_____Reaction:_____

_____Reaction:_____

_____Reaction:_____

Are you allergic to latex? (i.e. dentist gloves)

No □ Yes □ Reaction:_____

Please list past surgeries with date (month/year) and if you experienced any problems during or after surgery. (i.e. anesthesia problems, nausea or vomiting)

	Surgery	Date	Anesthesia Complications	Notes
1				
2				
3				
4				
5				
6				

Medications/Supplements (mg & directions):	**Reason why you take this medicine:**

What pharmacy do you use?_____ **Address**:_____
Pharmacy Phone Number:_____

Patient's present: weight_____ height_____

Have you been treated with steroids in the past 2 years? (i.e. Prednisone, Medrol) _____

Patient's ability to heal:

Does your skin appear fragile, burns easily?	No □	Yes □
Do you form thick or raised scarring from a cut or burn?	No □	Yes □
Do you wax or use depilatories on your face?	No □	Yes □
Do you ever get cold sores?	No □	Yes □
Do you have diabetes?	No □	Yes □
Do you smoke?	No □	Yes □

Female History	**Yes**	**No**	**N/A**	**Note**	**Date**
Do you have regular periods?					
Are you going through menopause?					
Are you pregnant or lactating?					
During pregnancy, did you ever get hyperpigmentation or masking?					
Are you done having children?					
Did you nurse your children?					

How many pregnancies have you had? _____
How many children do you have? _____
What are the ages of your children? _____

Mammogram
When was your last mammogram? _____
Was your last mammogram normal? _____. If not, please explain _____
When is your next mammogram scheduled? _____