PATIENT'S NAME ____

Primary Physician ____ **Physician's Clinic**______________________

Pharmacy _______________________ **City** ______________________ **Street** ______________________________

All MEDICAL CONDITIONS YOU HAVE BEEN TREATED FOR:

___ Arthritis
___ Elevated Blood Fats/Cholesterol or Triglycerides
___ Asthma
___ Hyperthyroidism
___ Skin Cancer: Type _________
___Diabetes
___ Hypothyroidism
___ Other Cancer: Type_________
___High Blood Pressure

LIST ALL MAJOR SURGERIES YOU HAVE HAD: ___ NONE (No Surgeries)

___ Cancer Surgery: Type __________
___ Joint Replacement
Knee R or L or both
Hip R or L or both
___ Heart Valve Replacement
___ Coronary Bypass
___ Other(s)_____________________________
____

MEDICATIONS THAT YOU ARE TAKING REGULARLY: ______I am currently NOT taking any medications

MEDICATION	MEDICATION	MEDICATION
___ Atorvastatin/Lipitor	___ Ibuprofen/Advil	Others (please list)
___ Contraceptives	___ Insulin	___________________
___ Citalopram	___ Levothyroxine	___________________
___ Enbrel	___ Lisinopril	___________________
___ Furosemide	___ Metformin	___________________
___ Humira	___ Methotrexate	___________________
___ Hydrochlorothiazide	___ Prednisone	___________________

ARE YOU TAKING ANY OF THE FOLLOWING BLOOD THINNERS?

___ Aspirin (dosage) ______ ___ Coumadin/Warfarin (dosage) ____ ___Plavix/Clopidogrel(dosage)______

MEDICATION ALLERGIES: ___ I have NO KNOWN Medication Allergies

___Penicillin(s) ___Sulfa ___Others (please list) _______________
____

IS THERE A FAMILY HISTORY OF MALIGNANT MELANOMA? ___ Yes ___ No

WHICH FAMILY MEMBERS: __ Mother __ Father __ Sister __ Brother __ Grandfather __Grandmother

SMOKING STATUS: ___Never ___ Former ___ Current

EMERGENCY CONTACT: NAME___________________________ **Phone Number:** __________________

Can we leave a detailed message on your voicemail?

___Yes ___No

Which is your preferred method of contact: Home ☐ Cell ☐ Work ☐

Please provide an e-mail address if you would like to receive appointment reminders___________________________