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Name (please print): _____

Referred by: Physician_____ **Patient**_____

HEIGHT: feet_____ **inches**_____ **WEIGHT: Lbs**_____

1. What is the reason for today's visit?

_____

2. Have you ever had or been treated for the following conditions: Please circle all that apply.

Arthritis/Rheumatoid Arthritis
Asthma
Bleeding Disorders
Cancer (please list)
Diabetes
Eye Disease
Hepatitis
High Blood Pressure
HIV, Aids or exposure
Kidney Problems
Lung Disease
Mental Illness: emotional or psychiatric problems
Osteoporosis
Phlebitis
Seizures/Stroke/Pacemaker/Heart Disease
Thyroid
Tuberculosis
Ulcers

3. Have you ever had any of the following?

Difficulty with healing of wounds	YES	NO	Overgrown scars or keloids	YES	NO
Excessive bleeding	YES	NO	Yeast infection from taking antibiotics (for women only)	YES	NO
Diarrhea from taking medications	YES	NO	A reaction to local or Dental anesthesia	YES	NO

4. List any prior surgery (include dates):

5. List all medications you are currently taking:

6. List all allergies to medications (Including Herbal, Food, Talc, Adhesive tape etc. If no allergies write none):

7. Social History:

Do you smoke?	YES	NO
Do you drink alcohol?	YES	NO
Do you use illicit drugs	YES	NO

8. PLEASE CIRCLE MEDICAL PROBLEMS THAT RUN IN YOUR FAMILY:

Arthritis/ Rheumatoid Arthritis	**High Blood Pressure**	**Seizures/Stroke/Pacemaker/Heart Disease**
Asthma	**HIV, Aids or exposure**	**Thyroid**
Bleeding Disorders	**Kidney Problems**	**Tuberculosis**
Cancer (please list)	**Lung Disease**	**Ulcers**
Diabetes	**Mental Illness/Emotional or psychiatric problems**	
Hepatitis	**Phlebitis**	**Does Melanoma run in your family? _____**

FOR WOMEN:

Are you currently pregnant or planning a pregnancy? **YES NO**

Are you taking birth control pills? **YES NO If yes NAME_____**

Are you sexually active? **YES NO**

If yes what method of Birth Control are using? _____

YOU *MUST* INFORM THE DOCTOR IF YOU BECOME (OR PLAN TO BECOME) PREGNANT DURING YOUR TREATMENT PERIOD

PATIENT SIGNATURE:_____ DATE:_____

DOCTOR SIGNATURE:_____ DATE:_____