New Patient Form

To serve you more efficiently, please complete this form and return it to the front desk before you are called to the exam room. Thank you.

Date:_____ Account Number:_____ Age: _____

Name:_____ Date of Birth: _____

Preferred Pharmacy Name & Zip Code:_____

Primary Care Provider:_____

Have you received the following vaccinations in the past year? (Circle answer)

Flu- Yes/No Pneumonia - Yes/No

Select any of the following medical conditions you currently have

- O Anxiety
- O Arthritis
- O Atrial Fibrillation
- O Bone Marrow Transplant
- O BPH
- O Breast Cancer
- O Colon Cancer
- O COPD
- O Coronary Artery Disease
- O Depression
- O Diabetes
- O End Stage Renal Disease
- O GERD
- O Hearing Loss
- O Hepatitis
- O Hypertension
- O HIV/AIDS
- O Hypercholesterolemia
- O Hyperthyroidism
- O Hypothyroidism
- O Leukemia
- O Lung Cancer
- O Lymphoma
- O Prostate Cancer
- O Radiation Treatment
- O Seizures
- O Stroke
- O Other

Past surgeries on the following organs

- O Appendix
- O Bladder
- O Breast
  - o Biopsy: RT/LT/both
  - o Lumpectomy: RT/LT/both
  - o Mastectomy: RL/LT/both
- O Colon
  - o Cancer Resection
  - o Diverticulitis
  - o Inflammatory Bowel Disease
  - o Colostomy
- O Gallbladder (cholecystectomy)
- O Heart
  - o Valve Replacement
  - o Stent (PTCA)
- O Joint Replacement
  - o Hip: RT/LT/both
  - o Knee: RT/LT/both
- O Kidney
  - o Biopsy
  - o Stone Removal
  - o Transplant
  - o Nephrectomy
- O Liver
  - o Hepatectomy
  - o Transplant
  - o Shunt
- O Ovaries
  - o Oophorectomy
  - o Endometriosis
  - o Ovarian cancer
  - o Ovarian Cyst
  - o Tubal Ligation
- O Pancreas (Pancreatectomy)
- O Prostate
  - o Prostatectomy
  - o Biopsy
  - o Prostate cancer
  - o TURP
- O Rectum
- O Skin
  - o Basal Cell Carcinoma
  - o Melanoma
  - o Skin Biopsy
  - o Squamous Cell Carcinoma
- O Spleen (Splenectomy)
- O Testicles (orchiectomy)
- O Uterus
  - o Hysterectomy
  - o Fibroids
  - o Uterine Cancer
  - o Cervical Cancer

Have you had any of the following skin conditions?

- ○ Acne
- ○ Actinic Keratosis
- ○ Asthma
- ○ Basal Cell Carcinoma
- ○ Blistering Sunburns
- ○ Dry Skin
- ○ Eczema
- ○ Flaking or Itchy Scalp
- ○ Hay fever/allergies
- ○ Melanoma
- ○ Poison Ivy
- ○ Precancerous Moles
- ○ Psoriasis
- ○ Squamous Cell Carcinoma
- ○ Other

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
Which Relative? _____

Current Medication List (Please place one per line. If you have a list, we can make a copy)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Medication Allergies

(List one per line- Please ask at front desk for additional form if needed)

1. _____
2. _____
3. _____
4. _____
5. _____

Describe the Reaction

Anaphylaxis Angioedema Diarrhea
Dizziness Fatigue GI Upset Hives
Liver Toxicity Nausea Rash
Shortness of Breath Swelling

Smoking History (Circle Answer)

Do you currently smoke? Yes/ No
If yes, do you smoke: Every day? Some days?
Former smoker? Yes/No

Surgical History (Circle Answer)

Do you bruise easily? Yes/ No
Have you ever had difficulty stopping bleeding? Yes/No
If you have an artificial joint, is it within the past 2 years? Yes/No
Do you have a artificial heart valve? Yes/No
Do you have a pacemaker? Yes/No
Do you have a defibrillator? Yes/No
Do you have an allergy to adhesive? Yes/No
Do you have an allergy to lidocaine? Yes/No
Pregnancy or planning to become pregnant? Yes/No