

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Chart#: \_\_\_\_\_ ALLERGIES: \_\_\_ NONE
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs.

Fitz: \_\_\_\_\_
\*\*\*REASON FOR VISIT TODAY:\*\*\*
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

LIST PROBLEM AREAS: (If Applicable)

- 1) \_\_\_\_\_; Duration: \_\_\_\_\_ Bleed /Scab/Crust: \_\_\_\_\_ Itch: \_\_\_\_\_ Pain: \_\_\_\_\_ ↑size: \_\_\_\_\_ Δ 'd color: \_\_\_\_\_
2) \_\_\_\_\_; Duration: \_\_\_\_\_ Bleed /Scab/Crust: \_\_\_\_\_ Itch: \_\_\_\_\_ Pain: \_\_\_\_\_ ↑size: \_\_\_\_\_ Δ 'd color: \_\_\_\_\_
3) \_\_\_\_\_; Duration: \_\_\_\_\_ Bleed /Scab/Crust: \_\_\_\_\_ Itch: \_\_\_\_\_ Pain: \_\_\_\_\_ ↑size: \_\_\_\_\_ Δ 'd color: \_\_\_\_\_

MEDICAL HISTORY: Please check if you have had any of the following:

- \_\_\_ Skin Cancer (BCC/SCC/Melanoma)
\_\_\_ Heart Problems (heart attack, chest pain, pacemaker, irregular heartbeat)
\_\_\_ Blood Thinning Medications (Aspirin, Coumadin, Plavix)
\_\_\_ High Blood Pressure
\_\_\_ Circulation Problems/Ankle Swelling
\_\_\_ Leg or Lung Clots
\_\_\_ Stroke, TIA, Seizure
\_\_\_ Asthma/Shortness of Breath/COPD/Sleep Apnea
\_\_\_ Anesthesia Problems/Airway Problems
\_\_\_ Diabetes (Oral Meds or Insulin)
\_\_\_ Thyroid Problems
\_\_\_ Cancer ( Type: \_\_\_\_\_ Date: \_\_\_\_\_)
\_\_\_ Recent Infection, Cold, Cold Sores, Herpes
\_\_\_ HIV, Hepatitis, Blood Transfusions
\_\_\_ Mental Health (depression, anxiety, eating disorders, cutting, etc.)

LIST MEDICATIONS:

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

FAMILY HISTORY:

Skin Cancer: \_\_\_\_\_
Melanoma: \_\_\_\_\_
Breast Cancer: \_\_\_\_\_
Anesthesia Problems: \_\_\_\_\_
Bleeding Problems/Clots: \_\_\_\_\_
Other: \_\_\_\_\_

SURGICAL HISTORY: (Please put year of surgery)

- \_\_\_ Breast (including biopsies) Right or Left Breast
\_\_\_ C-Section/ \_\_\_ Hysterectomy
\_\_\_ Appendectomy
\_\_\_ Gallbladder
\_\_\_ Past Cosmetic Surgery: \_\_\_\_\_
\_\_\_ Other Surgery: \_\_\_\_\_

SOCIAL HISTORY: Employer: \_\_\_\_\_

Ever Smoke? Y or N Amount? \_\_\_\_\_(/day) Quit When? \_\_\_\_\_ Alcohol Use? Y or N Amount? \_\_\_\_\_(/week)
Recreational Drug Use? Y or N Substance: \_\_\_\_\_

OFFICE USE ONLY:

- EXAM: \_\_\_ HEENT
\_\_\_ Respiratory
\_\_\_ Heart
\_\_\_ GI/GU
\_\_\_ Skin/Musc
\_\_\_ Neuro
\_\_\_ Heme/Lymph

IMPRESSION/PLAN:

NOTES: 1. Schedule
2. F/U prn