DEMOGRAPHIC INFORMATION

❑MR ❑MRS ❑MS ❑DR ❑____	NAME:		
ADDRESS			
EMAIL ADDRESS			
PHONE 1: ❑HOME ❑CELL ❑WORK		**PHONE 2:** ❑HOME ❑CELL ❑WORK	
BIRTHDATE (dd/mm/yyyy)		AGE:	
EMERGENCY CONTACT		EMERGENCY PHONE	

PREFERRED LANGUAGE	❑ ENGLISH ❑ SPANISH ❑_____	ETHNICITY	❑ NATIVE AMERICAN ❑ ASIAN ❑ BLACK ❑ PACIFIC ISLANDER ❑ WHITE ❑ OTHER_____	MARITAL STATUS	❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ SEPARATED ❑ WIDOWED

Do we have your permission to leave a message on an answering machine and/or with a family member?

PRIMARY CARE DOCTOR		
WOULD YOU LIKE A LETTER SENT TO THEM?	YES	NO
❑ YES ❑ NO	*Please sign:	

LIST ALL CURRENT MEDICATIONS:

LIST ALL CURRENT ALLERGIES: (LATEX / MEDICATIONS / EPINEPHRINE)

BLOOD THINNNERS: (ASPIRIN / PLAVIX / COUMADIN / PRADAXA)

PLEASE CONTINUE ON REVERSE:

MAIN REASON FOR YOUR VISIT TODAY:

MEDICAL & SURGICAL HISTORY: CHECK IF YOU HAVE BEEN OR ARE BEING TREATED FOR CONDITIONS/DISEASES BELOW

❑ANXIETY	❑COLON CANCER	❑HEARING LOSS	❑HYPOTHYROIDISM
❑ARTHRITIS	❑COPD	❑HEPATITIS	❑LEUKEMIA
❑ASTHMA	❑CORONARY ARTERY DISEASE	❑HYPERTENSION	❑LUNG CANCER
❑ATRIAL FIBRILATION	❑DEPRESSION	❑HIV / AIDS	❑LYMPHOMA
❑BONE MARROW TRANSPLANT	❑DIABETES	❑ANEMIA	❑PROSTATE CANCER
❑BPH	❑END STAGE RENAL DISEASE	❑HYPERCHOLESTEROLEMIA	❑RADIATION TREATMENT
❑BREAST CANCER	❑GERD	❑HYPERTHYROIDISM	❑SEIZURES
❑OTHER			❑STROKE
SOCIAL HISTORY	❑TOBACCO (PACKS/DAY)	❑ALCOHOL (DRINKS / WEEK)	
PAST SURGERIES	❑BREAST ❑COLON ❑HEART ❑JOINT ❑KIDNEY ❑OVARIES ❑PROSTATE ❑SKIN ❑TESTICLES ❑UTERUS		
EXPLAIN:			

PERSONAL HISTORY OF SKIN CANCER (BASAL CELL/SQUAMOUS CELL/ MELANOMA):

LOCATION ON BODY		DATE TREATED	
LOCATION ON BODY		DATE TREATED	

FAMILY HISTORY OF CANCERS:

	TYPE OF CANCER
SELF	❑DECEASED
GRANDPARENTS	❑DECEASED
FATHER	❑DECEASED
MOTHER	❑DECEASED
SISTERS	❑DECEASED
BROTHERS	❑DECEASED
CHILDREN	❑DECEASED

KNOWN PROBLEMS:

❑PROBLEMS WITH BLEEDING
❑PROBLEMS WITH HEALING
❑PROBLEMS WITH SCARRING
❑RECURRENT RASHES

SUN EXPOSURE HISTORY		# OF BLISTERING SUNBURNS	
PRIOR X-RAY TREATMENTS OR RADIATION			

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