



PATIENT MEDICAL HISTORY

Please complete entire questionnaire by checking all that apply

Social History: [] Never smoker [] Former smoker [] Current some day smoker [] Current every day smoker

Alcohol Use: [] None [] Less than 1 drink per day [] 1-2 drinks per day [] 3 or more drinks per day

Past Medical History:

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
(Irregular Heartbeat)
- Bone Marrow Transplantation
- Benign Prostatic Hyperplasia
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- Acid Reflux
- Hearing Loss
- Hepatitis
- Hypertension
- HIV/AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- None
- Other _____

Do you wear sunscreen?
[] Yes [] No

Do you tan in a tanning salon?
[] Yes [] No

Past Surgical History:

- Appendix Removal
- Bladder Removal
- Breast: Breast Biopsy
- Breast: Lumpectomy
(Right, Left, Both)
- Breast: Mastectomy
(Right, Left, Both)
- Colon Cancer Resection
- Diverticulitis
- Inflammatory Bowel Disease
- Colostomy
- Gallbladder Removal
- Biological Valve Replacement
- Coronary Artery Bypass
- Heart Transplant
- Mechanical Valve Replacement
- Angioplasty Surgery
- Hip Replacement
(Right, Left, Both)
- Knee Replacement
(Right, Left, Both)
- Kidney Biopsy
- Kidney Stone Removal
- Kidney Transplant
- Kidney Removal
(Right, Left)
- Liver Removal
- Liver Transplant
- Liver Shunt
- Endometriosis
- Ovarian Cancer
- Ovarian Cyst
- Tubal Ligation
- Pancreas Removal
- Prostate Biopsy
- Prostate Cancer
- TURP
- Abdominal Perineal Resection
- Low Anterior Resection
- Spleen Removal

- Testicle Removal
- Uterine Fibroids
- Uterine Cancer
- Cervical Cancer
- None
- Other _____

Skin Disease History:

- Acne
- Actinic Keratoses
- Asthma
- Basal Cell Skin Cancer
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking or Itchy Scalp
- Hay Fever/Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Skin Cancer
- None
- Other _____

Do you have a family history of Melanoma? [] Yes [] No

If yes, which relative?

Have you received a pneumonia vaccination?
[] Yes [] No