Pt#_____

PATIENT HEALTH INFORMATION

Name _____ Date of Birth _____

RACE: Please check one ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or other Pacific Islander ❑ White ❑ Other ❑ Unknown or Decline to provide

ETHNICITY: Please check one ❑ Hispanic or Latino ❑ Non-Hispanic or Non-Latino ❑ Unknown or Decline to provide

Have you ever been diagnosed with:

☐ Yes ☐ No HEPATITIS Type _____
☐ Yes ☐ No BLEEDING PROBLEMS
☐ Yes ☐ No FAMILY HISTORY OF MELANOMA Relationship?_____
*☐ Yes ☐ No SKIN CANCER - BASAL CELL CARCINOMA, SQUAMOUS CELL CARCINOMA, MELANOMA
If YES, please describe the type of skin cancer, location, treatment and date.

_____

_____

☐ Yes ☐ No CANCER (other than skin)*
If YES, please describe type and treatment and date.

_____

☐ Yes ☐ No POSITIVE HIV

PLEASE LIST ANY OTHER SIGNIFICANT MEDICAL PROBLEMS:

☐ Yes ☐ No High Blood Pressure ☐ Yes ☐ No Kidney Disease ☐ Yes ☐ No Heart Disease
☐ Yes ☐ No High Cholesterol ☐ Yes ☐ No Diabetes ☐ Yes ☐ No Liver Disease

Other: _____

☐ Yes ☐ No Have you ever had a Pneumonia Vaccination

☐ Yes ☐ No Do you smoke or have you smoked in the past? _____ Packs per day
☐ Yes ☐ No Do you use alcohol? _____ Drinks per day/week/month/year

Do you have or have you had:

☐ Yes ☐ No HEART MURMUR
☐ Yes ☐ No ARTIFICIAL HEART VALVE
☐ Yes ☐ No ARTIFICIAL JOINT
☐ Yes ☐ No HAYFEVER/ASTHMA
☐ Yes ☐ No ARE YOU PREGNANT/BREASTFEEDING?
☐ Yes ☐ No ARE YOU ON BIRTH CONTROL PILLS?
☐ Yes ☐ No UNEXPLAINED WEIGHT LOSS
☐ Yes ☐ No LATEX ALLERGY
☐ Yes ☐ No ALLERGY TO DENTAL ANESTHESIA
☐ Yes ☐ No ALLERGIC TO ANY MEDICATIONS?
Please List _____

☐ Yes ☐ No LUPUS
☐ Yes ☐ No KELOIDS/THICK SCARS
☐ Yes ☐ No PACEMAKER
☐ Yes ☐ No STROKE
☐ Yes ☐ No GASTROINTESTINAL DISORDER
☐ Yes ☐ No SEIZURES
☐ Yes ☐ No GLAUCOMA
☐ Yes ☐ No TB
☐ Yes ☐ No ARE YOU ON BLOOD THINNER?

PHARMACY:_____ LOCATION:_____

PRIMARY/FAMILY CARE PHYSICIAN:_____

PLEASE LIST PRESCRIBED MEDICATIONS INCLUDING STRENGTH AND DOSAGE

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Date _____ Signature _____
Patient or Parent/Guardian