

Name of Patient _____ Date of Birth _____ Today's Date _____

Past Medical History

	Yes	No		Yes	No
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>	Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>
Basal Cell Carcinoma	<input type="checkbox"/>	<input type="checkbox"/>	Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Squamous Cell Carcinoma	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Moles	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Gall Stones	<input type="checkbox"/>	<input type="checkbox"/>
Stents or Bypass Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Carotid Artery Blockage	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Esophageal Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Atrial Fibrillation/Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>		Yes	No
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Renal Failure	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Kidney Transplant	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Glomerulonephritis	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infections	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Polycystic Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Renal Cell Carcinoma	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>		Yes	No
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Juvenile Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Type 1 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Polymyalgia Rheumatica	<input type="checkbox"/>	<input type="checkbox"/>
Type 2 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Carcinoid Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Dermatomyositis	<input type="checkbox"/>	<input type="checkbox"/>
Addison's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sjogren's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Cushing's Disease	<input type="checkbox"/>	<input type="checkbox"/>		Yes	No
Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	Low Platelets	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots/DVT	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>		Yes	No
	Yes	No	Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>
Menopause	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
Polycystic Ovary Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Obsessive-Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Attention Deficit Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Uterine Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Autism	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>		Yes	No
	Yes	No	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
HIV-AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>
MRSA	<input type="checkbox"/>	<input type="checkbox"/>			

Social History

Alcohol Often Rarely Never Occupation _____
 Tobacco Smoker Former Smoker Never Smoked Marital Status _____

Family History

	Yes	No	Relation
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	_____