Name: ______________________________Date of Birth:_______________ Age: _________

Drug Allergies: ____

Medications: ____

____

Consult- Referring Doctor: __________________________

Current Problems with: (ROS)

	Yes	No	(If yes, explain)
General Health	☐	☐	____________________
Eyes	☐	☐	____________________
ENT/Mouth	☐	☐	____________________
Lung	☐	☐	____________________
Heart	☐	☐	____________________
GI	☐	☐	____________________
Kidneys	☐	☐	____________________
Arthritis/Joints	☐	☐	____________________
Skin	☐	☐	____________________
Headaches	☐	☐	____________________
Psych. Disorders	☐	☐	____________________
Seizures	☐	☐	____________________
Bleeding Disorders	☐	☐	____________________

Females: Are you pregnant? Yes_____ No_______ Planning to become pregnant? Yes_____No ____

Are you nursing? Yes____No ___

Past Medical History/Surgical/Family History

Mother: Living/Deceased Age________ Father: Living/Deceased: Age ______

Number of Children_______Ages(s) ______________________________

Check the following conditions that have occurred in you or your family

DISEASE	You	Relative	DISEASE	You	Relative
Melanoma	☐	☐	Cancer	☐	☐
Squamous Cell Carcinoma	☐	☐	Hepatitis	☐	☐
Basal Cell Carcinoma	☐	☐	High Blood Pressure	☐	☐
Abnormal Moles (Dysplastic)	☐	☐	Pacemaker	☐	☐
Psoriasis	☐	☐	Mitral Valve Prolapse	☐	☐
Eczema	☐	☐	Heart Valve Repl	☐	☐
Hives	☐	☐	Joint Replacement	☐	☐
Allergies/Hayfever	☐	☐	Liver Disease	☐	☐
Asthma	☐	☐	Seizures	☐	☐
Diabetes	☐	☐	HIV	☐	☐
Thyroid Issues	☐	☐	Other ________________	☐	☐

History of Sun Exposure: Minimal Moderate Severe

Do you use Sunscreens? Yes____ No____ SPF______

Past Surgeries (if applicable):____

Social History

Do you live alone? No *Yes* Married Do you smoke? No Yes Frequency?__________

Do you drink alcohol? No Yes Frequency_________ Recreational Drugs? No Yes Frequency_______

Occupation:____________________________Hobbies/Leisure:____________________________

**Established patient: PFSH____________(date) Reviewed ___________ No additions/changes___________

Patient Signature:____

Reviewed: ________________________________ Date:__________ Updated:_____________

Patrick Keehan, D.O.