SOUTHWEST SKIN CANCER AND VEIN CLINIC
PATIENT MEDICAL HISTORY

PtMedHxForm2-2016-6/20/17

Patient Name: ___________________________ **Primary Care Physician**: ____________________

Pharmacy: ____

Name Address Phone Fax

Current Medications, Vitamins, Supplements: □ **See List**

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

I am **ALLERGIC** to these medications:____

Smoking Status: □ Never □ Former □ Current: # of packs per day ____________

Has anyone in your **immediate** family had a skin cancer? □ Yes □ No If yes, who and what type: ______________

____

Occupation: ____

Reason for Today's Visit: ____

Circle If You Take:

Aspirin Pradaxa

Blood Thinners Vitamin E

Ginkgo Prednisone

Xarelto Plavix

Coumadin or Warfarin

Alerts: (Circle All That Apply)

Pacemaker Immunosuppression

Organ Transplant Defibrillator

Problems Healing MRSA

Artificial Heart Valve HIV or Hep C

Premedication Prior to Procedure

Have you had a Flu shot within the past 12 months?

Yes □ No □

Have you had a pneumonia shot (PPSV23 and PCV13) in the past 5 years?

Yes □ No □

(**IF INTERESTED IN VEIN EVALUATION please complete this section**)

Vein Disease Screen:
Check if you have or have had:
□ Pain or Aching
□ Cramping or Night Cramps
□ Itching
□ Swelling
For how long? _________months/yrs.

Do your symptoms interfere with your daily activities? □ Yes □ No

Have you ever had:

□ Abnormal Bleeding
□ Abnormal Clotting
□ Deep Vein Thrombosis
□ Leg Rashes
□ Leg Skin Discoloration
□ Superficial Thrombophlebitis
□ Leg Ulcers

Do you wear medical grade compression stockings?
□ Yes □ No
Do you elevate your legs? □ Yes □ No
Do you exercise regularly? □ Yes □ No
Have you ever had your leg veins treated?
□ Yes □ No
If so, how? ____________________

FEMALES ONLY:

Number of Pregnancies:_____ Number of Children:_______

Do have plans for future pregnancy? □ Yes □ No

FOR OFFICE USE ONLY

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