NAME: _____ Date of Birth: _____
E-Mail Address: _____
What is your preferred pharmacy (name & city) _____
May we send your pathology or labs to Boyce & Bynum? ___ If no what lab do you prefer? _____
What brings you in today? _____
What is your occupation? _____
How did you hear about us? TV RADIO FRIEND OTHER: _____

PAST MEDICAL HISTORY: <u>PLEASE CIRCLE ALL THAT APPLY TO YOU</u>

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood Pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Leukemia
Lung cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
NONE
OTHER:_____

PAST SURGICAL HISTORY: <u>PLEASE CIRCLE ALL THAT APPLY TO YOU</u>

Appendix removed
Bladder removed

Lumpectomy (right, left, bilateral)
Mastectomy (right, left, bilateral)
Breast Reduction
Breast Implants

Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD

Gall Bladder removed

Biological Valve Replacement
Coronary Artery Bypass
Heart Transplant
Mechanical Valve Replacement

Joint replacement, Hip (right, left, bilateral) Year_____
Joint replacement, Knee (right, left, bilateral) Year_____

Kidney Biopsy (Nephrectomy)
Kidney stone removal
Kidney Transplant
Kidney Removed (right, left)

Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer

Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)

Spleen Removal

Testicle Removed (right, left, bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
NONE
Other_____

SKIN DISEASE HISTORY: <u>PLEASE CIRCLE ALL THAT APPLY TO YOU</u>

Acne
Actinic Keratosis
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or itching scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell skin cancer
NONE
Other: _____

Do you wear Sunscreen? Yes No If yes, what SPF? _____
Do you tan in a tanning salon? Yes No
Do you have a family history of Melanoma? Yes No
If so, what member of the family? _____

MEDICATIONS: (**please list all current medications and dosages/strengths)**

_____
_____
_____
_____
_____

LIST ALL MEDICATIONS THAT YOU ARE ALLERGIC TO:

_____
_____
_____
_____

Allergy to Latex? YES or NO

SOCIAL HISTORY: PLEASE CIRCLE ALL THAT APPLY TO YOU

Alcohol Use:
None
Less than one drink a day
1-2 drinks day
3 or more a day

Smoking:
Current smoker
Never a smoker
Former smoker

REVIEW OF SYSTEMS: ***Please circle all that apply to you***
Problems with bleeding
Healing
Scarring (hypertrophic or keloid)
Rash
Immune suppression
Joint aches
Fever chills

ALERTS: ***PLEASE CIRCLE ALL THAT APPLY TO YOU***

Allergy to Adhesive
Allergy to Lidocaine
Allergy to topical antibiotics
Artificial Heart Valve
Artificial joint replacement
Blood Thinners
Defibrillator
Pacemaker
MRSA
Require antibiotics prior to surgery
Rapid Heart beat with epinephrine
Are you pregnant?
Are you currently trying to get pregnant?