411 N. Washington Ave, Suite 1200, Dallas, TX, 75246 P: 214-396-5227 F: 214-396-5445

MEDICAL HISTORY

PATIENT INFORMATION

Last Name:	First Name:	Date of Birth:

MEDICAL CONDITIONS (Check all that apply): ☐ None

☐ Artificial heart valve
☐ Artificial joints: ________year of most recent
☐ Vascular shunts
☐ Rheumatic heart disease
☐ Cardiac stents: ________year of most recent
☐ Stroke / TIA

☐ Pacemaker / defibrillator
☐ Bleeding problems
☐ Keloids
☐ HIV / AIDS
☐ Hepatitis A B C
☐ Organ transplant:
Type:________________
Year:_________

☐ Kidney disease
☐ Liver disease
☐ Diabetes
☐ Heart defect
☐ Endocarditis
☐ Atrial fibrillation
☐ Staph infection

☐ High blood pressure
☐ Previous skin cancer
☐ Mohs surgery
☐ Problems healing
Explain:_______________
____
☐ Seizures

FAMILY HISTORY (include only 1st degree relatives - parents, siblings, children) ☐ None

☐ Melanoma	Please specify which relative(s):

CURRENT MEDICATIONS (Check all that apply): ☐ None

☐ Aspirin
☐ Plavix/ clopidogrel
☐ Coumadin / warfarin
☐ Pradaxa / dabigatran

☐ Xarelto / rivaroxaban
☐ Aggrenox
☐ Brilinta / ticagrelor

☐ Eliquis / apixaban
☐ Other blood thinners
☐ Herbal supplements

☐ Vitamin E
☐ Steroids / Prednisone
☐ Fish or Flaxseed oil

Please list all other medications (prescribed and over-the-counter). Attach separate sheet if needed:

Medication allergies and type of reaction: ☐ None ☐ Latex

PHARMACY

Pharmacy Name and Address:	Phone Number:

SOCIAL HISTORY

Do you currently smoke or use tobacco? ☐ No ☐ Yes: ______# packs per day

Is there anything else you want your doctor to know that may affect treatment or recovery?

____

MRN__________ Date___________________ (for clinic use only)