

MEDICAL HISTORY

FULL NAME: _____ Name you would like us to use: _____

Were you referred by a physician? Yes / No. If No, how did you find us? _____
 If yes, name of referring Dr.: _____ Location: _____
 Primary Care Physician : _____ Location: _____

TODAY'S VISIT

Reason for today's visit: _____

MEDICAL HISTORY

Do you have any drug allergies? Yes / No. If yes, please list: _____
 Please list all medications (include over-the-counter): _____

Do you have any of the following? (If Yes, please explain below)

Breathing problems	Yes / No	Do you have a pacemaker or defibrillator?	Yes / No
Heart problems	Yes / No	Have you had problems with bleeding?	Yes / No
Liver problems	Yes / No	Are you on a blood thinner?	Yes / No
Hepatitis	Yes / No	Have you had abnormal scarring (keloid)?	Yes / No
Kidney problems	Yes / No	Do you take antibiotics before dental procedures?	Yes / No
Stroke	Yes / No	Do you have any risk of HIV?	Yes / No
HIV / AIDS	Yes / No	Do you smoke? Yes / No (If yes, packs/day _____)	
Cancer	Yes / No	Do you drink alcohol? Never / Occasionally / Regularly	
High blood pressure	Yes / No	Do you wear: glasses contacts dentures hearing aids	
Organ transplant	Yes / No	If female, are you pregnant? Yes / No / Not sure	
Artificial joint	Yes / No	List all previous surgeries: _____	
Artificial heart valve	Yes / No		

Explanation: _____

SKIN CANCER HISTORY

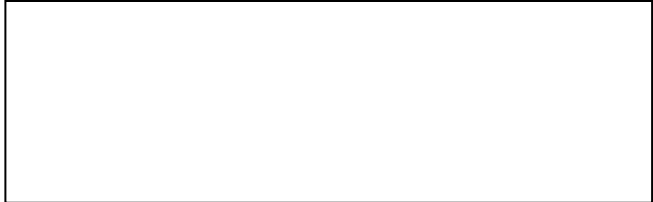
Have you ever had skin cancer? Yes / No If yes, what type? _____
 Has anyone in your family had skin cancer? Yes / No If yes, explain. _____
 Do you use a tanning bed? Regularly / Sometimes / Never / Not anymore.
 How many blistering sunburns have you had? _____
 Have you undergone ultraviolet (PUVA), or radiation treatments? Yes / No _____
 Do you examine your moles for changes? Yes / No Are any of your moles changing? Yes / No
 Occupation (if retired, then prior occupation): _____

PRIVACY POLICY

I acknowledge receiving a copy of Loudoun Medical Group's Notice of Privacy Practices.

Phone number to call with any biopsy reports or lab results: _____ Home / Work / Cell
 You have my permission to leave a message at the above phone number.
 Do not discuss my medical care with anyone but me.
 You have my permission to discuss my medical care with: _____

 Patient signature Date



(over please) _____