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General and Surgical Dermatology | Mohs Micrographic Skin Cancer Surgery Leg Vein Center | Laser and Cosmetic Surgery | Clinical Trials

PATIENT MEDICAL HISTORY

Last Name		First Nar	ne	M.I D.O.B//	_ Ag	e
Referring Physician or Source	(radio, tv, etc) _					_
Current (or previous) Dermato	logist			Primary Care Physician		
Pharmacy (name, city, & stree	t)			Occupation		
Training (training, only, or on oc	-7					
(patients 65+) Do you have a	health proxy/po	wer of at	torney? N	lame/Phone #		
MEDICATIONS (name an	d dose)			SURGICAL HISTORY	YES	NO
1. 7.				Do you take Coumadin, Plavix, Pradaxa, Xarelto,		
2.	8.			Eliquis, aspirin, or other blood thinners? If yes:		
3.	9.					
4.	10.			Do you have any artificial joints, heart valves, or		
5.	11.			other implanted material? If yes, please list:		
6.	12.					
				Do you routinely take antibiotics before dental		
ALLERGIES (please list w	ith reactions)		procedures?		
1.	3.	-		Have you ever had a reaction to anesthesia?		
2.	4.			Do you have liver or kidney disease?		
				Do you have a bleeding or clotting disorder?		
SKIN CANCER/FAMILY HISTORY YES NO				Do you have a pacemaker or defibrillator?		
Have you ever had basal cell c	or squamous cel					
carcinoma (BCC or SCC)?				PAST MEDICAL HISTORY	YES	NO
Data/lacations			•	Have you received a flu vaccine this year?		
Date/location:				Have you ever received a pneumococcal		
				vaccine?		
Have you ever had melanoma	?			Diabetes		
Date/location:				Heart disease		
Any family members with mel	anoma?			Have you ever tested positive for HIV/AIDS?		
Date/location: Any family members with othe	or ckin cancor?			Have you ever tested positive for Hepatitis A/B/C? Thyroid disease		
List:		•				<u> </u>
				Sexually transmitted diseases		
				Cancer (other than skin)		
PREGNANCY AND NURSI	NG			High blood pressure		
Are you currently pregnant, nursing, or attempting conception?				Herpes simplex (cold sores)		
		□YES	\square NO	Tuberculosis		
				Other conditions (please list):		
f pregnant, how many weeks	:] 		
SOCIAL HISTORY		YE	s NO			

PAST SURGICAL HISTORY (please list with dates)

Do you smoke?

- if yes, how many packs per day?

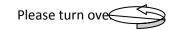
		1.	5.
Do you drink alcohol?		2.	6.
Do you use recreational drugs?		3.	7.
Do you exercise?		4.	8.

REVIEW OF SYSTEMS

For each question, check yes or no

CONSTITUTIONAL				١	YES	NO		MUSCULOSKELETAL	YES	NO
Fever						Muscle pain				
Weight loss						Back pain				
Chills							Joint pain/stiffness			
							_			
EYES								SKIN		
Vision loss								Psoriasis		
V131011 1033								Eczema		
Blurred vision										
							_	NEUROLOGIC		
EARS, NOSE, MOU	ITH, TH	IROAT						Headache		
Hearing loss								Dizziness		
Congestion/runny	nose							Numbness/tingling		
Sore throat										
							_	PSYCHIATRIC		_
CARDIOVASCULAF	₹					_		Depression		
Chest pain/pressur	re							Anxiety		
Palpitations								Sleep disturbance		
Swelling in the legs										
						_	ENDOCRINE			
RESPIRATORY							Cold/heat intolerance			
Shortness of breath							Night sweats			
Cough							Excessive urination			
							_			
GASTROINTESTINA	AL							HEMATOLOGIC/LYMPHATIC		
Nausea/vomiting							Easy bruising/bleeding			
Diarrhea							Anemia			
Decreased appetite										
Abdominal pain						ALLERGIC/IMMUNE		ı		
						Asthma				
GENITOURINARY						Hives				
Pain/burning with urination							Hay fever			
	VEIN SYMPTOMS									
			u have varico			T	ere	for a vein consultation)		
D : /A I :	YES	NO	6 11:		YES	NO	-	LIFESTYLE	YES	NO
Pain/Aching			Swelling				-	Does leg pain interfere with your daily life?		
Throbbing			Leg cramps					Is your discomfort getting worse?		
Tired/heavy legs			Restlessness				-	Are symptoms worse with prolonged standing?		
Itching					Do you take medication for leg pain?					
Family history of Varicose Veins?										
Ever worn support hose from a doctor?				□NO	1	stripping laser surgery inject				
• • • • • • • • • • • • • • • • • • • •			☐YE		□NO □NO	1	-if so, where & when?:	10112		
• • • • • • • • • • • • • • • • • • • •			☐YE		□NO	1] blood	clots	
Have you ever had a miscarriage?				<u>ا</u> ر		1	instary or (check applicable) prilebitis	<u>, 51000</u>	CIULO	

To the best of my knowledge, the above information is accurate and complete.



Patient Signature:	DATE:	
Reviewed by (provider signature):	DATE:	MA Initials: