JOHN A. ZITELLI, M.D. & DAVID G. BRODLAND, M.D.

Name_____ **DOB** _____ **Age** _____

EMAIL_____ **Home#**_____

Cell_____ **Preferred # [ ] home [ ] cell**

OK to Leave a Detailed Message @ this number? [ ] yes [ ] no

Pharmacy Name & phone:_____

Emergency: Contact Primary Name/Relation/phone#_____

Secondary Name/Relation/Phone#_____

Can we discuss health information with your emergency contact? [ ] yes [ ] no

Marital status: [ ] S [ ] M [ ] D [ ] W

Referred by: [ ] Self or [ ] Dr. _____

PCP name/phone#_____

Check all that apply regarding your past medical conditions and past surgical history

[ ] Anxiety disorders
[ ] Arthritis
[ ] Asthma
[ ] Atrial fibrillation
[ ] Bipolar disorder
[ ] Blood coagulation disorder
[ ] Breast cancer
[ ] CAD- Coronary artery disease
[ ] Cancer of prostate
[ ] Chronic obstructive lung dis.
[ ] Depressive disorder
[ ] Diabetes mellitus
[ ] Disease caused by Co-vid 19
[ ] Elevated blood pressure
[ ] End-stage renal disease
[ ] Epilepsy
[ ] Gastroesophagel reflux
[ ] Guillain-Barre synd.
[ ] Hepatitis B virus
[ ] Hepatitis C virus
[ ] High cholesterol
[ ] History of asthma
[ ] Hypertension
[ ] History of migraine
[ ] Thyroid disorder
[ ] History of tuberculosis
[ ] HIV Infection
[ ] Inflammatory bowel
[ ] Inflammatory liver
[ ] Leukemia
[ ] Malignant lymphoma
[ ] Malignant tumor of colon
[ ] Multiple sclerosis
[ ] Parkinson's disease
[ ] Radiation therapy treatment
[ ] Stroke

Please describe any other past medical conditions in the space below:

_____

_____

SURGICAL HISTORY:

[ ] Excision of ovary
[ ] History of colectomy
[ ] History of tubal ligation
[ ] Hysterectomy
[ ] Splenectomy
[ ] L hip joint replacement
[ ] L knee joint replacement
[ ] R hip joint replacement
[ ] R knee joint replacement
[ ] Organ transplant?
IF YES, which organ? _____

PLEASE DESCRIBE ANY OTHER PAST SURGERIES IN THE SPACE TO THE RIGHT:

_____

_____

PLEASE TURN OVER TO COMPLETE OTHER SIDE OF THIS PAPER

SKIN CONDITION HISTORY [ ] Acne [ ] Actinic Keratosis [ ] Dysplastic Nevi [ ] Eczema

[ ] Psoriasis [ ] Sunburn of second degree [ ] Additional conditions (please describe) _____

PAST HISTORY **PREVIOUS SKIN CANCER: [ ] None [ ] Yes/list: Type/Site & Date**_____

_____

Do you wear sunscreen: [ ] No [ ] Yes/What SPF?:_____

Do you tan in a tanning salon: [ ] No [ ] Yes

FAMILY HISTORY OF SKIN CANCER **[ ] None [ ] Basal cell [ ] Squamous cell [ ] Melanoma**

Relationship:_____

SOCIAL HISTORY **Occupation:**_____

Smoking: [ ] No [ ] Former [ ] Yes/packs per day_____

Alcohol: [ ] No [ ] YES **If yes, how many times in the past year have you had: Men:** ≥5 drinks in a day _____

Women: ≥4 drinks in a day_____ **Alcohol/Drug problems/addictions:** [ ] None [ ] Describe _____

Did someone other than the patient provide the information above? [ ] No [ ] Yes- who and why_____

MEDICATIONS AND ALLERGIES

Medication/OTC/Supplements	Dosage	Frequency	Route

NO MEDICATIONS [ ] **NO ALLERGIES TO MEDICATIONS [ ]**

Allergies to Medications	Reactions