RETURN PRIOR TO APPT DATE-COMPLETE BOTH SIDES

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. Height: __________ **Weight:**________

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

PCP name/phone#______________________________

Check all that apply regarding your past medical conditions/surgical history or check NONE

[ ] Anxiety disorders
[ ] Arthritis
[ ] Asthma
[ ] Atrial fibrillation
[ ] Autoimmune disorder
[ ] Bipolar disorder
[ ] Blood coagulation disorder
[ ] Cerebrovascular Accident
[ ] COPD
[ ] Coronary artery disease
[ ] Depressive disorder
[ ] Diabetes mellitus
[ ] Disease caused by Co-vid 19
[ ] Elevated blood pressure
[ ] End-stage renal disease
[ ] Epilepsy
[ ] Gastroesophageal reflux
[ ] Guillain-Barre syndrome
[ ] DVT
[ ] Hay fever
[ ] Migraine
[ ] Thyroid disorder
[ ] Tuberculosis
[ ] Heart valve disorder
[ ] Hepatitis B virus
[ ] Hepatitis C virus
[ ] HIV infection
[ ] Hypercholesterolemia
[ ] Inflammatory Bowel Disease
[ ] Inflammatory Liver Disease
[ ] Kidney disease
[ ] Leukemia
[ ] Lupus erythematosus
[ ] Malignant Lymphoma
[ ] Malignant Tumor of Breast
[ ] Malignant Tumor of colon
[ ] Malignant Tumor of Lung
[ ] Malignant Tumor of Prostate
[ ] Multiple Sclerosis
[ ] Parkinson's Disease
[ ] Radiation Therapy Treatment Mgmt.
[ ] Other______________________________
____
[ ] **NONE OF THE ABOVE**

PAST SURGERIES:

[ ] Tubal Ligation
[ ] History of colectomy
[ ] Hysterectomy
[ ] Oophorectomy
[ ] Splenectomy
[ ] L hip joint replacement
[ ] L knee joint replacement
[ ] R hip joint replacement
[ ] R knee joint replacement
[ ] Any Organ transplant?
IF YES, which Organ? ______________
[ ] **NO** surgeries
[ ] Other

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

____

____

SKIN CONDITION HISTORY [ ]NONE [ ] Acne [ ] Actinic Keratosis [ ] Basal Cell Carcinoma [ ] Dysplastic Nevi [ ]Eczema [ ]Malinant Melanoma[ ] Psoriasis[ ] Squamous Cell Carcinoma [ ]Sunburn of second degree

[ ]Other ____

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

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

FAMILY HISTORY OF Melanoma **[ ] None [ ]Mother[ ]Father[ ] Sister[ ] Brother[ ] Daughter[ ]Son[ ]Uncle [ ] Aunt [ ] Nephew [ ] Niece [ ] Grandmother[ ]Grandfather[ ] Grandson[ ] Granddaughter**

[ ] OTHER: ____

PLASTIC SURGERY HISTORY **[ ] None or List:**____

FAMILY HISTORY OF BREAST CANCER: **[ ] None, If yes, Relation:**____

SOCIAL HISTORY **Smoking**: [ ] No [ ] Former [ ] Yes/packs per day_____ If former: Start: _______ Quit: _______

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_____________ **OCCUPATION**:____

QUALITY MEASURES: **Do you have a MEDICAL Power of Attorney? [ ] No [ ] Yes If yes, give name and phone #**____ **Do you have a living will? [ ] No [ ] Yes**

NO MEDICATIONS [ ] NO ALLERGIES TO MEDICATIONS [ ] or list below:

MEDICATIONS AND ALLERGIES

Medication/OTC/Supplements	Dosage	Frequency	Route

Allergies to Medications	Reactions

REVISED: 4/10/23 JH