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Patient Name: _____ Today's Date: ____/____/____

Chief Complaint: _____

PLEASE CHECK THE BOX FOR THE CONDITIONS YOU HAVE NOW OR HAVE HAD IN THE PAST:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Chicken Pox - Age: __ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Aids | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriages | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gonorrhea/Chlamydia | <input type="checkbox"/> Moles | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Gout | <input type="checkbox"/> Polio | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hair/Nail Disorder | <input type="checkbox"/> Pre-Cancerous Lesions | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Prostate Problem | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psychiatric Care | |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rash | |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rheumatic Fever | |

Have you ever had surgery? If so, list operations and dates:

Do you have allergies to medications or foods? If so, please list: _____

Allergy to Neomycin: YES NO

Allergy to Latex: YES NO

Allergy to Lidocaine: YES NO

Allergy to Epinephrine: YES NO

MEDICATION LIST:	DOSAGE	FREQUENCY

Do you take aspirin, aspirin like products or blood thinners? YES NO

GENERAL

Have you ever smoked cigarettes? YES NO

If yes, how many per day? _____

Do you drink alcohol? YES NO

If yes, how much per day? _____

Do you use recreational drugs? YES NO

If yes, what type? _____

How much caffeine (coffee, tea, soda) do you drink per day? _____

HAS ANY BLOOD RELATIVE HAD ANY OF THE FOLLOWING?

- | | |
|---|--|
| <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> Malignant Melanoma |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Squamous Cell Carcinoma |

FEMALE PATIENTS ONLY:

- Are you currently?
- | | |
|-----------------------------|--|
| Taking birth control: | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Pregnant: | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Breast Feeding: | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Taking hormone replacement: | <input type="checkbox"/> YES <input type="checkbox"/> NO |