Name_____**DOB**_____**Date**_____

Circle any of the following medical conditions that pertain to you, past or present:

Anxiety	Asthma	Atrial Fibrillation
Anxiety w/ medical procedures	COPD	Heart Blockage
Depression	Diabetes	Kidney Disease
Hepatitis	HIV/AIDS	High Blood Pressure
Thyroid Disorder	Seizures	Stroke
Pacemaker/defibrillator	Heart valve problem	Organ transplant
Cochlear Implant		

Skin Cancer: Melanoma Basal Cell Squamous Cell

Body Location: _____Year_____

Artificial Joint: Site_____Date_____

Other medical conditions not listed:_____

Past Surgeries:_____

Allergies: Medications_____

Other: (latex, contrast dye)_____

Blood Thinners (include aspirin, fish oil)_____

Prescribing physician_____

Family history of skin cancer: Melanoma Basal Cell Squamous Cell Unknown

Relationship to patient_____

Do you take antibiotics prior to procedures? Yes No Reason_____

Vaccines: Flu:_____Year_____Pneumonia_____Year_____