

# Steve Oberemok M.D., Inc.

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

## Past Medical History/Surgeries (Check All That Apply)

Anxiety \_\_\_\_\_

Asthma \_\_\_\_\_

COPD \_\_\_\_\_

Depression \_\_\_\_\_

End Stage Renal Disease \_\_\_\_\_

Hepatitis \_\_\_\_\_ Type \_\_\_\_\_

HIV/AIDS \_\_\_\_\_

Hypothyroidism \_\_\_\_\_

Hyperthyroidism \_\_\_\_\_

Radiation Treatment \_\_\_\_\_

Stroke \_\_\_\_\_

Seizures \_\_\_\_\_

Valve Replacement \_\_\_\_\_

Arthritis \_\_\_\_\_

Atrial Fibrillation \_\_\_\_\_

Coronary Artery Disease \_\_\_\_\_

Diabetes \_\_\_\_\_

Hearing Loss \_\_\_\_\_

High Blood Pressure \_\_\_\_\_

Cancer History/Location(s) \_\_\_\_\_

\_\_\_\_\_

Past Cancer Surgeries \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other \_\_\_\_\_

\_\_\_\_\_

## Skin Disease History (Check All That Apply)

Acne \_\_\_\_\_

Dry Skin \_\_\_\_\_

Flaking or Itching Scalp \_\_\_\_\_

Hay Fever/ Allergies \_\_\_\_\_

Blistering Sunburns \_\_\_\_\_

Psoriasis \_\_\_\_\_

Do you use sunscreen? Yes [ ] No [ ]

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

Eczema \_\_\_\_\_

Actinic Keratoses \_\_\_\_\_

Basal Cell Skin Cancer \_\_\_\_\_

Squamous Cell Skin Cancer \_\_\_\_\_

Melanoma \_\_\_\_\_

Do you have a family history of

Malignant Melanoma ? Yes [ ] No [ ]

If yes, which relative? \_\_\_\_\_

**Medications: (Please write all current medications and medication strengths)**

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**Allergies: (Please write all drug allergies and reactions)**

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**Cigarette Smoking:**

Currently \_\_\_\_\_ In The Past \_\_\_\_\_

Never Smoked \_\_\_\_\_

**How many times have you had more than 4**

**alcoholic drinks in one day, in the past year?**

0 [ ] 1 [ ] 2 [ ] 3 [ ] 4+ [ ]

**Height:** \_\_\_\_\_

**Weight:** \_\_\_\_\_

**Preferred Language:** \_\_\_\_\_

**Race:** \_\_\_\_\_ **Ethnic Group:** \_\_\_\_\_

**Preferred Pharmacy Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**City or Zip Code:** \_\_\_\_\_ **Cross Streets:** \_\_\_\_\_

**Alerts (please check all that apply)**

Allergy to Adhesive \_\_\_\_\_

Allergy to Lidocaine \_\_\_\_\_

Allergy to Topical Antibiotics \_\_\_\_\_

Blood Thinners \_\_\_\_\_

Defibrillator \_\_\_\_\_

MRSA \_\_\_\_\_

Pacemaker \_\_\_\_\_

Rapid heart beat with epinephrine \_\_\_\_\_

Require antibiotics prior to surgical procedure \_\_\_\_\_

Pregnant or trying to get pregnant \_\_\_\_\_

Received Flu Vaccine \_\_\_\_\_

Received Pneumonia Vaccine \_\_\_\_\_