Transformations Skin & Body Solutions LLC

Please answer all the questions as accurately as possible. Please turn this sheet over and fill in the information on the back.

Last Name _____ First _____ RECORD # _____ Date _____

What do you need to be seen for? _____

What is your Age _____ Male / Female Which hand is your dominant one? Right / Left / Use Both Equally

Do you have any Hobbies or Talents? Y / N What are they? _____

What are your DRUG ALLERGIES? None _____

Drug Name _____ Effect _____

Drug Name _____ Effect _____

Drug Name _____ Effect _____

What are the MEDICATIONS YOU TAKE? I take NO Medications at all _____

Drug Name _____ Dose _____ Drug Name _____ Dose _____

Drug Name _____ Dose _____ Drug Name _____ Dose _____

Drug Name _____ Dose _____ Drug Name _____ Dose _____

Drug Name _____ Dose _____ Drug Name _____ Dose _____

Do you take aspirin or Ibuprofen daily or almost every day? Y / N

YOUR OWN PAST MEDICAL HISTORY: Have you had?

☐ *NO Medical Propblems	☐ Asthma	☐ Gastric Ulcer	☐ Kidney Disease	☐ Peripheral Vasc Dz	☐ Stomach Ulcer
☐ Acne	☐ Atopic Derm Eczema	☐ Glaucoma	☐ Long Term (Current) Drug Tx	☐ Psoriasis	☐ Stroke
☐ Acquired Coag Defect Specified	☐ Cirrhosis	☐ Heart Disease - Coronary Artery	☐ Lymphedema	☐ Radiation/Chemo	☐ Thyroid Disorder
☐ Acquired Coag Factor Deficiency	☐ CTCL	☐ Heart Valve Disease	☐ Migraine	☐ Rheumatoid Arthritis	☐ Tuberculosis
☐ Allergic Rxn to Drug	☐ Dementia Lwey Bodies	☐ Hepatitis	☐ MRSA	☐ Roscea	☐ Venous Insuff
☐ Anemia	☐ Depression	☐ HIV	☐ Obesity	☐ Seizures	☐ Venous Thrombo Embolism
☐ Anxiety General	☐ Diabetes Mellitus	☐ Hyperlipidemia	☐ Obesity Morbid	☐ Sleep Apnea	
☐ Anxiety Specified	☐ Discoid Lupus	☐ Hypertension	☐ Other Specified Disorder Skin	☐ Spontaneous Eccymosis	
☐ Arthritis	☐ Eczema	☐ Immunosuppressed Due Med	☐ Parkinson Dz	☐ Stasis Dermatitis	

Skin History

☐ * I have not had any skin cancers	☐ Where you born in the South or lived here for 10 years	☐ Warts
☐ Prior I had Melanoma	☐ Did you spend alot of time outside in the sun?	☐ Do you have/had repearted cold sores or Shingles(zoster)?
☐ Prior I had Squamous Cell Cancer	☐ Have you ever had any blistering sunburns?	
☐ Prior I had Basal Cell Cancer	☐ Did you ever work outdoors?	
☐ Any family history of skin cancers?	☐ Tanning bed use	

WHAT ARE YOUR PREVIOUS SURGERIES, MAJOR ILLNESSES, AND HOSPITALIZATIONS?

I have never had any type of surgery, ever _____

	Details
* I have not had any surgery	
Abdominal	
Accidents	
Cancer Related	
Cardiac	
Cosmetic Surgery	
Ear, Nose, Throat	
Eye Surgery	
Female Surgery	
Fractures	
Implants	
Joint Replacement	
Male Surgery	
Organ Transplant	
Other	
Spine	

FAMILY HISTORY: Have any immediate family members had? ☐ Adopted

☐ *NO Medical Propblems	☐ Asthma	☐ Gastric Ulcer	☐ Kidney Disease	☐ Peripheral Vasc Dz	☐ Stomach Ulcer
☐ Acne	☐ Atopic Derm Eczema	☐ Glaucoma	☐ Long Term (Current) Drug Tx	☐ Psoriasis	☐ Stroke
☐ Acquired Coag Defect Specified	☐ Cirrhosis	☐ Heart Disease - Coronary Artery	☐ Lymphedema	☐ Radiation/Chemo	☐ Thyroid Disorder
☐ Acquired Coag Factor Deficiency	☐ CTCL	☐ Heart Valve Disease	☐ Migraine	☐ Rheumatoid Arthritis	☐ Tuberculosis
☐ Allergic Rxn to Drug	☐ Dementia Lwey Bodies	☐ Hepatitis	☐ MRSA	☐ Roscea	☐ Venous Insuff
☐ Anemia	☐ Depression	☐ HIV	☐ Obesity	☐ Seizures	☐ Venous Thrombo Embolism
☐ Anxiety General	☐ Diabetes Mellitus	☐ Hyperlipidemia	☐ Obesity Morbid	☐ Sleep Apnea	
☐ Anxiety Specified	☐ Discoid Lupus	☐ Hypertension	☐ Other Specified Disorder Skin	☐ Spontaneous Eccymosis	
☐ Arthritis	☐ Eczema	☐ Immunosuppressed Due Med	☐ Parkinson Dz	☐ Stasis Dermatitis	

Last Name _____ First_____ RECORD #_____ Date _____

What age did your mother die? _____ What did she die from? _____
What medical problems did she have? _____
What age did your father die? _____What did he die from? _____
What medical problems did he have? _____

SOCIAL HISTORY:
Were you ever a smoker? Yes / No
If so, at the most how many packs per day did you smoke? 1/4 1/2 1 2 3
What year did you start? _____ What year did you quit? _____
Have you travelled outside the United States recently? Y / N Where _____
Do you use any illicit substances (ILLEGAL DRUGS) Y / N If so what _____
Chemical Exposure at work? Y / N If so what _____
Do you drink any alcohol almost daily? Y/ N If so how many drinks per day? _____
How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day _____

Have you had a Flu Shot Yes / No If yes at work or home (Circle) Month _____ Year _____
If not why (Circle) Do not want Allergy No Reason Not Available
Have you had a Pneumonia Shot Yes / No If yes at work or home (Circle) Month _____ Year _____
If not why (Circle) Do not want Allergy No Reason Not Available

WOMEN ONLY:
Date of Last Period _____ Number of Pregnancies _____ Date Last Mammogram _____
Is there any reasonable chance you are pregnant? Yes / No

Cardiovascular

	Admits
chest pain	☐
dizziness	☐
shortness of breath	☐
palpitations	☐

Respiratory

	Admits
Chronic cough	☐
wheezing	☐
congestion	☐
shortness of breath	☐

Hematology / Lymph

	Admits
Easy bleeding	☐
Easy bruising	☐
anemia	☐
enlarged glands	☐

Musculoskeletal

	Admits
joint pain/swelling	☐
stiffness	☐
muscle pain	☐
back pain	☐

Neurological

	Admits
headaches	☐
memory loss	☐
loss of strength	☐
paralysis	☐
numbness	☐

Genitourinary

	Admits
frequent urination	☐
painful urination	☐
blood in urine	☐
Discharge	☐
bladder leakage	☐

Ears, Nose, Throat

	Admits
sore throat	☐
sinus trouble	☐
stuffy nose	☐
hearing loss	☐
nosebleeds	☐

Psychiatric

	Admits
anxiety	☐
depression	☐
mood swings	☐
difficulty sleeping	☐
homicidal thoughts	☐
suicidal thoughts	☐

Gastrointestinal

	Admits
Acid reflux/Heartburn	☐
nausea/vomiting	☐
change in appetite	☐
abdominal pain	☐
constipation	☐
diarrhea	☐

Allergic / Immunologic

	Admits
hives	☐
eczema	☐

Eyes

	Admits
Blurred vision	☐
eye irritation	☐

Endocrine

	Admits
loss of hair	☐
heat/cold intolerance	☐

What do you Weigh in pounds? _____ What is your Height in inches _____

If you have a Cardiologist what is His / Her name? _____

****YOU ARE RESPONSIBLE FOR COMPLETING THIS FORM Transformations Skin & Body Solutions AND ITS EMPLOYEES ARE NOT RESPONSIBLE FOR PROBLEMS ARISING FROM YOUR ERRORS and OMISSIONS****

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE:

Signature of Patient or Guardian: _____ Date: _____/_____/_____ rev 4/8/20