GWD-CD MEDICAL FORM

NAME:___________________________

PAST MEDICAL HISTORY*—Please circle any you have or had:*

Anxiety	Coronary Artery Disease	Hypercholesterolemia	Seizures
Arthritis	Depression	Stomach ulcers/digestive	Stroke
Asthma	Diabetes	Hyperthyroidism	
Atrial Fib/irregular heartbeat	End stage renal disease	Hypothyroidism	Other problems—
BPH	GERD	Leukemia	*list:_____________________
Bone marrow transplant	Hearing loss	Lung cancer	_________________________
Breast cancer	Hepatitis	Lymphoma	_________________________
Colon cancer	Hypertension	Prostate cancer	_________________________
COPD	HIV/AIDS	Radiation treatment	____________________

LIST ANY SURGERIES:____

SKIN HISTORY*-- Please circle any you have or had:*

Acne	Dry skin	Melanoma	Squamous cell skin cancer		
Actinic keratoses	Eczema	Poison ivy	Do you wear sunscreen?	Yes	No
Asthma	Flaking/itchy scalp	Precancerous moles	Is there family history of melanoma?	Yes	No
Basal Cell skin cancer	Hay fever/allergies	Psoriasis			

CURRENT MEDICATIONS:

ALLERGIES: Are you allergic to any medications? If so, please list below

Medication	What happens? (eg. hives, trouble breathing, etc)

SMOKING HISTORY (CIRCLE ONE): everyday smoker some day smoker former smoker never smoker

CIRCLE any you have below: (ROS)

Problems with bleeding	Thyroid problems	Seizures	Artificial joint
Problems with healing	Sore throat	Cough	Blood thinners
Problems with scarring	Blurry vision	Shortness of breath	Defibrillator
Rash	Abdominal pain	Wheezing	MRSA
Immunosuppression	Bloody stool	Anxiety	Pacemaker
Hay fever	Bloody urine	Depression	Rapid heart beat with epinephrine
Chest pain	Joint aches	Allergy to adhesive	
Fever or chills	Muscle weakness	Allergy to lidocaine	**Pregnancy/planning pregnancy**
Night sweats	Neck stiffness	Allergy to topical antibiotic	
Unintentional weight loss	Headaches	Artificial heart valve	