JOSEPH E. McKEOWN, M.D., P.C.

Patient Name: _____ Date: _____

Chief Complaint: _____ Height: _____ Weight: _____

CURRENT MEDICATIONS

_____

_____

_____

MEDICATION ALLERGIES

_____

_____

_____

SURGICAL HISTORY

_____

_____

_____

PATIENT MEDICAL HISTORY

	Y	N
BLOOD THINNER:	❑	❑
Plavix	❑	❑
Coumadin	❑	❑
Aspirin	❑	❑
Motrin/Advil	❑	❑
Other: _____		
HYPERTENSION	❑	❑
HEART OR CORONARY ARTERY DISEASE	❑	❑
DIABETES:	❑	❑
Insulin	❑	❑
Oral Medication	❑	❑

	Y	N
PREVIOUS HISTORY OF SKIN CANCER:	❑	❑
Melanoma	❑	❑
Basal Cell Carcinoma	❑	❑
Squamous Cell Carcinoma	❑	❑
BLEEDING TENDENCY	❑	❑
HISTORY OF ANESTHESIA PROBLEMS	❑	❑
MITRAL VALVE PROLAPSE	❑	❑
STROKE	❑	❑
MIGRAINE HEADACHES	❑	❑
HERNIA	❑	❑

	Y	N
THYROID DISEASE	❑	❑
ASTHMA	❑	❑
HEART MURMUR	❑	❑
EPILEPSY	❑	❑
ARTHRITIS	❑	❑
HEPATITIS	❑	❑
KIDNEY DISEASE	❑	❑
BACK TROUBLE	❑	❑
PACEMAKER/DEFIBRILLATOR	❑	❑

DATE OF LAST CHEST X-RAY _____/_____/_____

OTHER _____

_____

REVIEW OF SYSTEMS

EYES	Y	N
EYE DISEASE OR INJURY	❑	❑
WEAR GLASSES/CONTACT LENSES	❑	❑
BLURRED OR DOUBLE VISION	❑	❑

RESPIRATORY	Y	N
CHRONIC OR FREQUENT COUGHS	❑	❑
SPITTING OF BLOOD	❑	❑
SHORTNESS OF BREATH	❑	❑
WHEEZING	❑	❑

CARDIOVASCULAR	Y	N
HEART TROUBLE	❑	❑
CHEST PAIN OR ANGINA PECTORIS	❑	❑
PALPITATIONS	❑	❑
SHORTNESS OF BREATH WALKING	❑	❑
SHORTNESS OF BREATH LAYING FLAT	❑	❑
SWELLING OF FEET OR ANKLES	❑	❑

INTEGUMENTARY (SKIN/BREAST)	Y	N
BLOODY, ULCERATED LESIONS	❑	❑
RASH OR ITCHING	❑	❑
CHANGE IN SKIN COLOR	❑	❑
CHANGE IN HAIR OR NAILS	❑	❑
VARICOSE VENIS	❑	❑
BREAST PAIN	❑	❑
BREAST LUMP	❑	❑

FAMILY HISTORY OF SKIN CANCER

	Y	N	IF YES, LIST TYPE OF SKIN CANCER
FATHER	❑	❑	_____
MOTHER	❑	❑	_____
SIBLINGS	❑	❑	_____
CHILDREN	❑	❑	_____

PATIENT SOCIAL HISTORY

MARITAL STATUS ❑Single ❑Married ❑Separated ❑Divorced ❑Widowed

USE OF ALCOHOL ❑Never ❑Rarely ❑Moderate ❑Daily

USE OF TOBACCO ❑Never ❑Quit _____(date) ❑Current ___pks/daily

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any change in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

SIGNATURE OF PATIENT (OR PARENT IF MINOR) **DATE**