

## PATIENT HISTORY

*This is confidential medical information.  
Accurate and complete medical information is needed to help us provide optimal care.*

### ALLERGIES TO MEDICATIONS (list medication and type of reaction):

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### MEDICATIONS (list medications you are currently taking, including herbals and over-the-counter medicines):

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### MEDICAL HISTORY

Have you ever had skin cancer? If yes, please list type, date and location: \_\_\_\_\_

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Have you previously been *diagnosed* with any chronic skin conditions? If yes, please list: \_\_\_\_\_

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Have you ever had the following? (check all that apply)

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> AIDS/HIV               | <input type="checkbox"/> depression                        | <input type="checkbox"/> heart attack/disease             | <input type="checkbox"/> psychiatric disease          |
| <input type="checkbox"/> allergies              | <input type="checkbox"/> diabetes                          | <input type="checkbox"/> hepatitis, type: _____           | <input type="checkbox"/> radiation, explain:<br>_____ |
| <input type="checkbox"/> arthritis              | <input type="checkbox"/> genetic disease; type:<br>_____   | <input type="checkbox"/> high blood pressure              | <input type="checkbox"/> seizures                     |
| <input type="checkbox"/> asthma                 | <input type="checkbox"/> GI, bowel disease, type:<br>_____ | <input type="checkbox"/> lupus                            | <input type="checkbox"/> stroke                       |
| <input type="checkbox"/> bleeding disorder      | <input type="checkbox"/> glaucoma                          | <input type="checkbox"/> multiple sclerosis               | <input type="checkbox"/> thyroid disease              |
| <input type="checkbox"/> cancer, type:<br>_____ |  | <input type="checkbox"/> organ transplant, type:<br>_____ | <input type="checkbox"/> tuberculosis                 |

Other chronic or current medical condition(s) not listed above: \_\_\_\_\_

Do you have any of the following? (check all that apply):

- pacemaker or defibrillator    prosthesis    artificial heart valve    joint replacement

Do you require antibiotics prior to surgical or dental procedures?  Yes  No

Are you pregnant or planning pregnancy?  Yes  No

Are you breastfeeding?  Yes  No

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(continued from page 1)

**FAMILY HISTORY** (please check all that apply):

	Mom	Dad	Sibling	Child
Skin Cancer (non melanoma type)				
Melanoma				
Asthma				
Allergies				
Eczema				

**SOCIAL HISTORY** (please check all that apply):

Do you use tanning beds?  Yes  No

Have you ever had a blistering sunburn?  Yes  No

Do you smoke?  Yes  No

**REVIEW OF SYSTEMS** (please check all that apply):

Please check any of the symptoms you are *currently* experiencing?

- weight loss (unintentional)
- fever
- fatigue
- nausea/vomiting
- sore throat
- abdominal pain
- swollen lymph nodes
- bleeding problem
- changes in vision
- cough
- shortness of breath
- muscle/joint pain
- chest pain
- allergy symptoms
- pain urinating
- depression/anxiety

Please check here if you are in your usual state of good health.

Provider's Initials: \_\_\_\_\_

**TODAY'S VISIT**

What is the reason for today's appointment? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

As a courtesy to our patients with scheduled appointments, we cannot evaluate or treat anyone who does not have an appointment. Sometimes we are able to accommodate additional patient appointments so please inquire if interested.