

Please indicate if you currently have, or have recently had any of the following. If you did not already give the details above, please provide them here or on back.

	Yes	No	Details
Rash	<input type="checkbox"/>	<input type="checkbox"/>	_____
New or changing mole	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding spot	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unusual bruising	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fever/chills/sweats	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nausea/vomiting/diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headache	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint pains	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unusual weight change	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pacemaker/defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	_____
Artificial joint(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart valve problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unusual bleeding problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heavy scarring/keloids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____

Who referred you to this office? _____

Who is your primary care physician? _____

Medical History reviewed by: