Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’sDate: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

**Patient Health Questionnaire (PFSH)** Please answer ALL questions

**Select any of the following medical conditions that you have**

|  |  |
| --- | --- |
| ❑ None |  |
| ❑ Anxiety | ❑ Hearing Loss |
| ❑ Arthritis | ❑ Hepatitis |
| ❑ Asthma | ❑ Hypertension |
| ❑ Atrial Fibrillation (Irregular Heartbeat) | ❑ HIV / AIDS |
| ❑ Bone Marrow Transplantation | ❑ Hypercholesterolemia |
| ❑ BPH | ❑ Hyperthyroidism |
| ❑ Breast Cancer | ❑ Hypothyroidism |
| ❑ Colon Cancer | ❑ Leukemia |
| ❑ COPD | ❑ Lung Cancer |
| ❑ Coronary Artery Disease | ❑ Lymphoma |
| ❑ Depression | ❑ Prostate Cancer |
| ❑ Diabetes | ❑ Radiation Treatment |
| ❑ End Stage Renal Disease | ❑ Seizures |
| ❑ GERD | ❑ Stroke |
| ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

**Past Surgeries: Have you had any surgeries on the following organs?**

|  |  |
| --- | --- |
| ❑ None |  |
| ❑ Appendix (Appendectomy) | ❑ Kidney : Kidney Biopsy |
| ❑ Bladder (Cystectomy) | ❑ Liver: Shunt |
| ❑ Breast : Breast Biopsy | ❑ Ovaries (Oophorectomy) : Endometriosis |
| ❑ Breast : Lumpectomy (Both Breasts) | ❑ Ovaries (Oophorectomy) : Ovarian Cancer |
| ❑ Breast : Lumpectomy (Left Breast) | ❑ Ovaries (Oophorectomy) : Ovarian Cyst |
| ❑ Breast : Lumpectomy (Right Breast) | ❑ Ovaries: Tubal Ligation |
| ❑ Breast : Mastectomy (Both Breasts) | ❑ Pancreas: Pancreatectomy |
| ❑ Breast : Mastectomy (Left Breast) | ❑ Prostate (Prostatectomy) : Prostate Biopsy |
| ❑ Breast : Mastectomy (Right Breast) | ❑ Prostate (Prostatectomy) : Prostate Cancer |
| ❑ Colon (Colectomy) : Colon Cancer Resection | ❑ Prostate (Prostatectomy) : TURP |
| ❑ Colon (Colectomy) : Diverticulitis | ❑ Rectum: APR |
| ❑ Colon (Colectomy) : Inflammatory Bowel Dz | ❑ Rectum: Low Anterior Resection |
| ❑ Colon: Colostomy | ❑ Skin : Basal Cell Carcinoma |
| ❑ Gallbladder (Cholecystectomy) | ❑ Skin : Melanoma |
| ❑ Heart : Biological Valve Replacement | ❑ Skin : Skin Biopsy |
| ❑ Heart : Coronary Artery Bypass Surgery | ❑ Skin : Squamous Cell Carcinoma |
| ❑ Heart : Heart Transplant | ❑ Spleen (Splenectomy) |
| **Past Surgeries: Have you had any surgeries on the following organs?**  ❑ Heart : Mechanical Valve Replacement | ❑ Testicles (Orchiectomy) |
| ❑ Heart : PTCA | ❑ Uterus (Hysterectomy) : Fibroids |
| ❑ Joint Replacement : Hip (Both) | ❑ Uterus (Hysterectomy) : Uterine Cancer |
| ❑ Joint Replacement : Hip (Left) | ❑ Uterus (Hysterectomy): Cervical Cancer |
| ❑ Joint Replacement : Hip (Right) | ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ❑ Joint Replacement : Knee (Both) |  |
| ❑ Joint Replacement : Knee (Left) |  |
| ❑ Joint Replacement : Knee (Right) |  |

**Have you had any of the following skin conditions?**

|  |  |
| --- | --- |
| ❑ None |  |
| ❑ Acne | ❑ Flaking or Itchy Scalp |
| ❑ Actinic Keratoses | ❑ Hay Fever/Allergies |
| ❑ Asthma | ❑ Melanoma |
| ❑ Basal Cell Skin Cancer | ❑ Poison Ivy |
| ❑ Blistering Sunburns | ❑ Precancerous Moles |
| ❑ Dry Skin | ❑ Psoriasis |
| ❑ Eczema | ❑ Squamous cell skin cancer |

Do you wear sunscreen? ❑ Yes ❑ No

If Yes, what SPF? \_\_\_\_\_\_\_\_

Do you tan in a tanning salon?❑ Yes ❑ No

**Family History:**

Do you have a family history of melanoma?❑ Yes ❑ No

If yes, which relative?

|  |  |
| --- | --- |
| ❑ Mother | ❑ Aunt |
| ❑ Father | ❑ Nephew |
| ❑ Sister | ❑ Niece |
| ❑ Brother | ❑ Grand mother |
| ❑ Daughter | ❑ Grand father |
| ❑ Son | ❑ Grand son |
| ❑ Uncle | ❑ Grand daughter |

**Social History:**

Smoking

|  |
| --- |
| ❑Unknown if ever smoked |
| ❑Current everyday smoker |
| ❑Current some day smoker (tobacco) |
| ❑Current some day smoker (cigarette) |
| ❑Former smoker |
| ❑Never smoker |
| ❑Smoker, current status unknown |
| ❑Cigar smoker |
| ❑Heavy tobacco smoker |
| ❑Light tobacco smoker |

Other

|  |  |
| --- | --- |
| ❑None |  |
| ❑Not sexually active | ❑Alcohol EtOH none |
| ❑Sexually active with one partner | ❑Alcohol EtOH less than 1 drink per day |
| ❑Sexually active with more than one partner | ❑Alcohol EtOH 1-2 drinks per day |
| ❑Same sex partner | ❑Alcohol EtOH 3 or more drinks per day |
| ❑Drug use | ❑Patient feels safe at home |
| ❑IV Drug Use | ❑Patient feels unsafe at home |

Driving Status

❑Drive in the daytime ❑Drive at night

**Review of Systems:**

| **Yes** | **No** | **Name** | **System** |
| --- | --- | --- | --- |
| ❑ | ❑ | High blood pressure | Cardiovascular |
| ❑ | ❑ | Chest pain | Cardiovascular |
| ❑ | ❑ | Heart attack | Cardiovascular |
| ❑ | ❑ | Shortness of breath | Respiratory |
| ❑ | ❑ | Stroke | Cardiovascular |
| ❑ | ❑ | Unintentional weight loss | Constitutional / Symptom |
| ❑ | ❑ | Depression | Psychiatric |
| ❑ | ❑ | Diabetes | Endocrine |
| ❑ | ❑ | Thyroid problems | Endocrine |
| ❑ | ❑ | Anemia | Hematologic / Lymphatic |
| ❑ | ❑ | Blood transfusion | None |
| ❑ | ❑ | Cancer | Other |
| ❑ | ❑ | Multiple sclerosis/numbness | Neurological |
| ❑ | ❑ | Lupus | Allergic / Immunologic |
| ❑ | ❑ | Arthritis/muscle pain | Musculoskeletal |
| ❑ | ❑ | Rheumatic disease | Allergic / Immunologic |
| ❑ | ❑ | Asthma/hay fever | Allergic / Immunologic |
| ❑ | ❑ | Emphysema | Respiratory |
| ❑ | ❑ | Malaise (feel sick) | Constitutional / Symptom |
| ❑ | ❑ | Fever or chills | Constitutional / Symptom |
| ❑ | ❑ | Headaches | Neurological |
| ❑ | ❑ | Fever blisters/cold sores | Other |
| ❑ | ❑ | Problems with bleeding | Hematologic / Lymphatic |
| ❑ | ❑ | Problems with healing | Integumentary |
| ❑ | ❑ | Problems with scarring (hypertrophic or keloid) | Integumentary |
| ❑ | ❑ | Rash | Integumentary |
| ❑ | ❑ | Immunosuppression | Allergic / Immunologic |
| ❑ | ❑ | Night sweats | Constitutional / Symptom |
| ❑ | ❑ | Sore throat | ENT and Mouth |
| ❑ | ❑ | Blurry vision | Eyes |
| ❑ | ❑ | Abdominal pain | Gastrointestinal (G.I.) |
| ❑ | ❑ | Bloody stool | Gastrointestinal (G.I.) |
| ❑ | ❑ | Bloody urine | Genitourinary (G.U.) |
| ❑ | ❑ | Muscle weakness | Musculoskeletal |
| ❑ | ❑ | Neck stiffness | Musculoskeletal |
| ❑ | ❑ | Seizures | Neurological |
| ❑ | ❑ | Cough | Respiratory |
| ❑ | ❑ | Wheezing | Respiratory |
| ❑ | ❑ | Anxiety | Psychiatric |

**Alerts:**

| **Yes** | **No** | **Name** |
| --- | --- | --- |
| ❑ | ❑ | **Artificial joints** |
| ❑ | ❑ | **Artificial heart valve** |
| ❑ | ❑ | **Pacemaker/defibrillator** |
| ❑ | ❑ | **Blood clots** |
| ❑ | ❑ | **Tuberculosis** |
| ❑ | ❑ | **HIV/AIDS** |
| ❑ | ❑ | **Hepatitis B or C** |
| ❑ | ❑ | **Liver problem** |
| ❑ | ❑ | **Kidney problems** |
| ❑ | ❑ | **Allergy to lidocaine/dental anesthesia** |
| ❑ | ❑ | **Allergy to adhesive** |
| ❑ | ❑ | **Allergy to latex** |
| ❑ | ❑ | **Allergy to topical antibiotic ointments** |
| ❑ | ❑ | **Blood thinners** |
| ❑ | ❑ | **MRSA** |
| ❑ | ❑ | **Premedication prior to procedures** |
| ❑ | ❑ | **Rapid heart beat with epinephrine** |
| ❑ | ❑ | **Pregnancy or planning a pregnancy** |

**Current Medications:**

**Allergies:**

**Patient/Guardian Signature :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**