Clocktower Medical Group
Brian McNiece, MD, Family Medicine

Patient Name: _____

Date of Birth: _____

HISTORY FORM

PLEASE FULLY COMPLETE THE REASON(S) FOR YOUR VISIT TODAY:

1. Reason for today's visit? _____

2. How long have you had this problem? _____

3. What location of your body is affected? _____

4. What are your symptoms (i.e. itching, burning, pain)? _____

5. Does anything make your problem worse? _____

6. Does anything make your problem better? _____

7. Does this problem affect your sleep? _____

8. How does this affect your life? _____

9. Have you been evaluated for this problem before? _____

   If so, by whom? _____

10. What was the diagnosis given?_____

11. Did you receive any treatment? _____

12. What was the treatment and how often did you receive it? _____

13. Is there anyone in your family with similar symptoms? _____

_____ INITIALS

_____ DATE

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Patient Name: _____

Date of Birth: _____

Primary Care Provider: _____ Phone #: _____

Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Asthma
Arterial Fibrillation (irregular heartbeat)
Bone Marrow Transplant
Benign Prostate Hyperplasia/BPH
Breast Cancer
Colon Cancer
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD/IBS
Hearing Loss
Hepatitis
Hypertension/BP
HIV/Aids
High Cholesterol
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Strokes

Other:

_____

_____

_____

Past Surgical History**:**

SURGERY	**YEAR OF PROCEDURE**	**SURGEON**

Height: _____ Weight: _____

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Skin Disease History: (Please check all that apply)

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Other:
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Squamous Cell Skin Cancer

_____

_____

_____

Do you wear sunscreen? ☐ YES ☐ NO

If yes, what SPF? _____

Do you tan in a tanning salon? ☐ YES ☐ NO

Do you have a family history of Melanoma? ☐ YES ☐ NO

If yes, which relatives? _____

_____

Medications: (Please list all medications)

_____

_____

_____

Allergies: (Please list all allergies)

_____

_____

_____

_____

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Social History: (Please check all that apply)

- ☐ Currently Smokes
- ☐ Has Smoked in the Past
- ☐ Drug Use
- ☐ None
- ☐ Other:

_____

Cautions: (Please check all that apply)

- ☐ Artificial Joints Within Past 2 Years
- ☐ Pacemaker
- ☐ Coronary Artery Pressure
- ☐ Artificial Heart Valve
- ☐ HIV/AIDS
- ☐ Blood Thinners
- ☐ Pre-medication Prior to Procedures
- ☐ Allergy to Latex
- ☐ Pregnant or Planning Pregnancy
- ☐ History of Low Blood or Platelet Count
- ☐ Use of Oxygen
- ☐ Prior Chemotherapy

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