Greg Krenek, M.D.

MEDICAL HISTORY

PATIENT NAME: ____ **DATE:** _____________

Please explain the reason for your visit with the doctor today:

____

PAST MEDICAL HISTORY: Do you personally have any of these problems? Circle all that apply.

Atypical Moles	Thyroid Disease	Organ Transplant	Liver Disease
Basal Cell Carcinoma	Diabetes	Stroke	Arthritis
Malignant Melanoma	High Blood Pressure	Kidney Problems	HIV
Squamous Cell	Heart Problems	Breathing Problems	Defibrillator
Carcinoma	Artificial Joint /Valve	Cancer	Pacemaker
Keloids (thick scars)	Hepatitis	Bleeding Problems	
Immunosuppressed	Psychiatric Condition	Blood Clots	

Other: ____

FAMILY HISTORY: Do any of these problems run in your family? Circle any that apply.

Malignant Melanoma	Dysplastic Nevi (abnormal moles)	Psoriasis	Lupus

SOCIAL HISTORY:

What is your occupation? ____

How many times in your life do you estimate you have had blistering sunburn? ___________

Do you drink alcohol? **Y** or **N** If yes, how many drinks per day? _______ per week _______

Do you smoke? **Y** or **N** If yes, how many packs per day? _______

Do you use drugs? **Y** or **N** If yes, what type? __________________ How often? _______________

REVIEW OF SYSTEMS: Circle all pertinent complaints

Trouble Healing	Fatigue	Headaches
Bleeds Excessively	Heartburn	Swollen Lymph Nodes
Weight Loss	Weight Gain	Dizziness
Leg Swelling	Joint Aches	Diarrhea
Nausea	Vomiting	Chronic Cough

Females Only: Circle all pertinent items.

Irregular Periods	Heavy Menstrual Cycles	Pregnant
Breastfeeding	Planning Pregnancy	