

M.D. SAUNDERS, M.D., P.C.

3950 Shore Road, Williamsburg, MI 49690

TEL (231) 938-7004

FAX (231) 938-3112

Name	Phone Number	Primary Care Provider
Address		Date

List all Medicationsblood thinners (aspirin, NSAIA, coumadin, or pain killers).....birth control pills
over-the-counter medications or supplements (vitamins, herbals, stool softeners, decongestants, pain killers)

List Allergies to Medications:

	Yes	No		Yes	No		Yes	No
Recent weight loss or gain	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Internal Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Type:		
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma or Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Eye problems	<input type="checkbox"/>	<input type="checkbox"/>	Reactions to the Sun	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Ear, nose, throat problem	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary disease	<input type="checkbox"/>	<input type="checkbox"/>	Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis in the legs	<input type="checkbox"/>	<input type="checkbox"/>	COPD or Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Mouth problems or Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Poor Healing	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorder or Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Scarring (keloids)	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma or Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>	Stroke, Seizures or Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	any weakness or lack of feeling	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Currently Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative colitis or Crohn's	<input type="checkbox"/>	<input type="checkbox"/>	Attempting Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease or Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Currently Nursing	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric (Depression)	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Infections	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety or Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Immunosuppression	<input type="checkbox"/>	<input type="checkbox"/>			

List any other medical diseases or conditions:

List any major surgeries, major accidents, or radiation therapy:

Occupation?

Hobbies?

Do you Smoke? Y N Drink Alcohol? Y N Use IV drugs? Y N Ever had a blood transfusion? Y N

Ever been exposed to hepatitis? Y N Ever been exposed to the AIDS virus? Y N

Any significant sun exposure?

Have you ever had skin cancer? Y N (if so, list type and location)

List Relevant Family History (skin cancer, melanoma, hair loss, asthma, hay fever, eczema, inherited diseases, skin problems?)