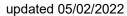


Last Name First Middle Initial Date of Birth / / Sex: M F Preferred Contact Phone # Address  City State Zip Email  Emergency Contact Name/Relationship Phone#  Do you prefer we deliver test results to you, semergency contact or both?  Emergency contact must be listed on your HIPAA paperwork.  Primary Care Physician PCP Phone # Preferred Pharmacy Location Phone#  Referring Physician (if any)  Medical History  Have you been diagnosed with or had any of the following conditions/treatments?  Diabetes mellitus yes no Depression yes no Anxiety yes no Pacemaker/defibrillator yes no Pacemaker/defibrillator yes no Other Implanted device yes no Artificial joints yes no Artificial heart valves yes no Asthma yes no Bleeding disorder yes no Bleeding disorder yes no COPD yes no Bleeding disorder yes no Memory problems yes no Anticoagulant treatment yes no Memory problems yes no Cancer yes yes no Memory problems yes no Anticoagulant treatment yes no Memory problems yes no Cancer yes no Cancer yes yes no Memory problems yes no Cancer yes no Cancer yes yes no Memory problems yes no Cancer yes yes no Memory problems yes yes no Cancer yes no Cancer yes no Memory yes no Cancer yes no Cancer yes no Memory yes yes no Cancer yes no Cancer yes no Cancer yes yes no Cancer yes no Cancer yes no Cancer yes yes no Cancer yes yes no Cancer yes yes no Cancer yes yes no Cancer yes yes no Cancer yes no Canc
Address City State Zip Email  Emergency Contact Name/Relationship Phone# Do you prefer we deliver test results to \$\( \) you, \$\( \) emergency contact \$\( \) or both?  Emergency contact must be listed on your HIPAA paperwork.  Primary Care Physician PCP Phone # Preferred Pharmacy Location Phone# Referring Physician (if any)   Medical History  Have you been diagnosed with or had any of the following conditions/treatments?  Diabetes mellitus \$\( \) yes \$\( \) no
Address City State Zip Email  Emergency Contact Name/Relationship Phone# Do you prefer we deliver test results to \$\( \) you, \$\( \) emergency contact \$\( \) or both?  Emergency contact must be listed on your HIPAA paperwork.  Primary Care Physician PCP Phone # Preferred Pharmacy Location Phone# Referring Physician (if any)   Medical History  Have you been diagnosed with or had any of the following conditions/treatments?  Diabetes mellitus \$\( \) yes \$\( \) no
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Primary Care Physician Location Phone#
Medical History  Have you been diagnosed with or had any of the following conditions/treatments?  Diabetes mellitus  yes  no Depression  yes  no Heart disease  yes  no Anxiety  yes  no High blood pressure yes  no Pacemaker/defibrillator  yes  no Other Implanted device  yes  no Dementia  yes  no Artificial joints  yes  no Artificial joints  yes  no Artificial heart valves  yes  no Artificial heart valves  yes  no Arthritis  yes  no Dementia  yes  no Arthritis  yes  no Arthritis  yes  no Arthritis  yes  no Dementia  yes  no Arthritis  no Dementia  yes  no Arthritis  no Dementia  no Dementia  no Dementia  no Depression  yes  no Artificial joints  no Dementia  no Dementia  no Dementia  no Dementia  no Dementia  no Depression  no Depres
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Have you been diagnosed with or had any of the following conditions/treatments?  Diabetes mellitus  yes  no  Depression  yes  no  Heart disease  yes  no  Anxiety  yes  no  High blood pressure  yes  no  Pacemaker/defibrillator  yes  no  Other Implanted device  yes  no  Other Implanted device  yes  no  Artificial joints  yes  no  Artificial joints  yes  no  Pre-dental work antibiotics  yes  no  Artificial heart valves  yes  no  Arthritis  yes  no  Arthritis  yes  no
Diabetes mellitus  yes  no Depression  yes  no Heart disease  yes  no Anxiety  yes  no High blood pressure  no Pacemaker/defibrillator  yes  no Other Implanted device  yes  no Artificial joints  yes  no Artificial joints  yes  no Pre-dental work antibiotics  yes  no Artificial heart valves  yes  no Arthritis  yes  no Arthritis  yes  no Depression  no Artificial heart valves  yes  no Arthritis  yes  no Arthritis  yes  no Depression  no Depression  yes  no Depression  no Depression  no Depression  yes  no Depression  no Notice  no Depression  no Depression  no D
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Heart disease  yes  no  Anxiety  yes  no  Pacemaker/defibrillator  yes  no  Other Implanted device  yes  no  Artificial joints  yes  no  Artificial joints  yes  no  Artificial heart valves  yes  no  Arthritis  no
High blood pressure by yes by no High cholesterol by yes by no Dementia by yes by no Arrythmia by yes by no Fainting/syncope by yes by no Asthma by yes by no Arthritis COPD by yes by no Thyroid disease by yes by no Kidney disease  Pacemaker/defibrillator  A yes by no Other Implanted device by yes by no Artificial joints  Pre-dental work antibiotics by yes by no Arthritis  Arthritis  By yes by no Clotting disorder  Anticoagulant treatment  Syes by no Anticoagulant treatment  A yes by no Anticoagulant treatment  Syes by no Anticoagulant treatment
High cholesterol  yes no Other Implanted device  yes no Artificial joints  yes no Arrythmia  yes no Pre-dental work antibiotics yes no Artificial heart valves  yes no Arthritis  yes no Arthritis  yes no Arthritis  yes no Bleeding disorder  yes no Clotting disorder  yes no Anticoagulant treatment yes no Anticoagulant treatment
Arrythmia
Arrythmia  Fainting/syncope  yes no  Artificial heart valves  Arthritis  yes no  Arthritis  yes no  Arthritis  yes no  Arthritis  yes no  COPD  yes no  Bleeding disorder  yes no  Clotting disorder  yes no  Anticoagulant treatment  yes no  Anticoagulant treatment
Fainting/syncope  yes  no
Asthma
COPD
Kidney disease  yes no Anticoagulant treatment yes no
Memory problems to yes to no Cancer to yes to no
Crohn's disease \$\sqrt{\sq}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}
Ulcerative colitis 5 yes 5 no Leukemia 5 yes 5 no
Lupus <b>5</b> yes <b>5</b> no Organ transplant <b>5</b> yes <b>5</b> no
Psoriasis
Eczema
Hay fever <b>5</b> yes <b>5</b> no HIV Positive <b>5</b> yes <b>5</b> no
Cold sore/HSV 5 yes 5 no Hepatitis 5 yes 5 no
Hearing Loss <b>5</b> yes <b>5</b> no Autism <b>5</b> yes <b>5</b>
no
MS/ALS/neurologic disease ≸ yes ≸ no Other:

Name\_\_\_\_\_ DOB\_\_\_\_

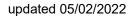


Women's only history:					
Are you pregnant? 🏂 yes 🏂 no					
If yes, how many weeks pregnant are you?					
Are you currently nursing? 🏂 yes 🟂 no					
Are you currently using any form of pregnancy contraception? 🕏 yes 🏂 no					
If yes, please list the form (oral, intra-uterine, implantable, etc):					
Skin Cancer History					
Do you have a personal history of melanoma? 🏂 yes 🟂 no					
Do you have a family history of melanoma? 🏂 yes 🏂 no					
Relationship:					
Do you have a personal history of non-melanoma skin cancer (for example, basal cell					
carcinoma, squamous cell carcinoma etc., other skin cancer)? ≸ yes ≸ no					
If yes, please list the skin cancer type:					
Vaccinations					
Are your immunizations up to date? <b>§</b> yes <b>§</b> no					
Have you received the influenza vaccine? ≸ yes ≸ no					
Have you received the shingles/herpes zoster vaccine? ≸ yes ≸ no					
Have you received the Covid vaccine? <b>ഉ</b> yes <b>ഉ</b> no					
Allergies					
Do you have any known medication, adhesive or other allergy? <b>5</b> yes <b>5</b> no					
If the answer is No, you may skip to the section titled Current Medications.					
Do you have an allergy to lidocaine? <b>5</b> yes <b>5</b> no					
Do you have an allergy to epinephrine? 🏂 yes 🏂 no Do you have an allergy to latex? 🏂 yes 🏂 no					
Do you have an allergy to adhesive tape? 🏂 yes 🏂 no					
Please list any known allergies below:					
Ticase not any known anorgies below.					
<del></del>					
Occurred Martin et al.					
Current Medications					
18					
2. 9.					
29					





10					
4	11	•			
5	12	•			
6	13	•			
7	14				
•	any supplements (ie. prenatal, vita , please list below:	amin D, St. John's wo	ort)? 🏂 yes 🏂 no 		
	Past Surgical	History			
Type of surg (Include Left	ery or Right side when appropriate)	Year —————	_		
	Social His	torv	_ _ 		
Do you smol If yes If yes Do you enga Do you drink If yes Have you ha Have you ha Do you use s	tobacco? So yes So no ke cigarettes? So yes So no for how many years have you smoon, for how many years have you smoon, please list the number of packs years in recreational drug use? So years alcohol? So yes So no for how many alcoholic beverages do all exposure to tanning beds? So years but blistering sun burns in the past? So sunscreen regularly? So yes So no today's visit:	ou smoke per day: _ es ၨ≸ no o you consume per w es ၨ≸ no			
Are you <u>cur</u> Fever	rently having any of the followir  ≸ yes ≸ no	ng symptoms? Joint pain ≸	voc it no		
Chills	yes your one of the second of	•			
	by yes by no		Muscle aches <b>≸</b> yes <b>≸</b> no Headache <b>≸</b> yes <b>≸</b> no		
•	★ yes ★ no		Easy bruising <b>½</b> yes <b>½</b> no		
	★ yes ★ no		Rash/itch <b>b</b> yes <b>b</b> no		
•	ain <b>≸</b> yes <b>≸</b> no		en lymph nodes 🏂		
		Name	DOB		



Name\_\_\_\_\_ DOB\_\_\_\_



Nausea no	≸ yes ≸ no Eye pain or discomfort ≸ yes ≸					
Vomiting	ၨ≸ yes ၨ≸ no breath or difficulty breathing ≸ yes or ၨ∫	<b>t</b> no	Diarrhea Cough	≸ yes ≸ no ≸ yes ≸ no		
	love to hear how you heard about the practive ways to integrate into and serve our commit		This is importa	ant so we can		
<ul><li>Referred by</li><li>Social Medi</li></ul>	r primary care physician r family/friend: a (Facebook, Toledo Clinic adds)					
Appointment No-Show, Change & Cancellation Policy						
care and resp change or ca appointments Patients arriv reschedule. T appointment service proc Payment is r	natology at the Toledo Clinic strives to proceed a medical appointment and 48-housed more than 20 minutes after the appointment no-show fee is \$50 for medical appointment appointment appointment appointment appointment will require componrefundable if you are unable to manage to motice during business hours.	ce wil r notice pintme point ntme plete	I require <u>24-lee</u> for cosme ont start time ments, \$200 nts. Certain payment in	nour notice to tic service may have to for surgical cosmetic advance.		
This policy al our patients.	lows our office to function with efficiency	ا and	orovide the b	est care to all of		
Please sign of	ate and time to communicate acceptant	ce of t	his policy.			
Signature her	re	Date_	<del></del>	Гіте		