PATIENT MEDICAL HISTORY

Name:_____ DOB:_____ Language:_____ Race:_____ Ethnicity:_____

PERSONAL AND FAMILY HISTORY

(Please indicate the afflicted family member: Parent, Sibling, Grandparent (maternal/paternal), Son or Daughter)

Condition	Self	Family Member	Condition	Self	Family Member
Anxiety			Hearing Loss		
Arthritis			Hepatitis (List Type: A, B, C)		
Asthma			High Blood Pressure		
Atrial Fibrillation			HIV/AIDS		
Bone Marrow Transplantation			High Cholesterol		
Breast Cancer			Leukemia		
Colon Cancer			Lymphoma		
COPD			Prostate Cancer		
Coronary Artery Disease			Radiation Treatment		
Depression			Seizures		
Diabetes (List Type I or II)			Stroke		
End Stage Renal Disease			Thyroid (List Hypo or Hyper)		
GERD					
OTHER:					

SURGICAL HISTORY (PLEASE INCLUDE COSMETIC SURGERIES)

Surgery/Hospitalizations	Date	Anesthesia Complications

SKIN DISEASE HISTORY (CHECK ALL THAT APPLY)

☐ Acne
☐ Actinic Keratoses
☐ Asthma
☐ Basal Cell Skin Cancer
☐ Blistering Sunburns
☐ Dry Skin
☐ Eczema
☐ Flaking or Itchy Scalp
☐ Hay Fever/Allergies
☐ Melanoma
☐ Poison Ivy
☐ Precancerous Moles
☐ Psoriasis
☐ Squamous Cell Carcinoma
☐ NONE
☐ OTHER:
_____
_____
_____
_____
_____
_____

☐ Yes ☐ No Do you wear sunscreen? If yes, what SPF? _____
☐ Yes ☐ No Do you tan in a tanning salon?
☐ Yes ☐ No Do you have a family history of melanoma? If yes, which relative(s)? _____

PATIENT MEDICATION LIST

Name:_____ DOB:_____ Language:_____ Race:_____ Ethnicity:_____

PRESCRIPTION MEDICATIONS

NAME OF MEDICATION	DOSAGE	FREQUENCY	BY MOUTH OR INJECTION

OVER THE COUNTER MEDICATIONS/SUPPLEMENTS

MEDICATION/SUPPLEMENT	DOSAGE	FREQUENCY

ALLERGIES (PLEASE LIST ALL ALLERGIES—WRITE "NONE" IF NONE)

_____

_____

SOCIAL HISTORY (PLEASE CHECK ALL THAT APPLY)

Cigarette Smoking:

☐ Currently smokes
☐ Never smoked
☐ Former smoker

Alcohol Use:

☐ None
☐ Less than 1 drink per day
☐ 1-2 drinks per day
☐ 3 or more drinks per day

PHARMACY INFORMATION

Preferred Pharmacy:

Pharmacy Name:_____

Phone #: _____

City or Zip Code: _____

PRIMARY CARE PHYSICIAN

Name of Physician: _____

Phone #: _____

City or Zip Code: _____

REFERRING PHYSICIAN

Name of Physician: _____

Phone #: _____

City or Zip Code: _____