TODAY'S DATE: ____________

NAME: ______________________________ **DATE OF BIRTH:** ____________

What is the reason for this office visit? ______________________________

Past Medical History: (please circle all that apply)

Anxiety	Diabetes	Leukemia
Arthritis	GERD (Acid reflux)	Lymphoma
Asthma	Hepatitis	Pacemaker/Defibrillator
Atrial Fibrillation	Hypertension	Radiation Treatment
Bone Marrow Transplantation	HIV/AIDS	Seizures
COPD (Emphysema)	Hypercholesterolemia	Stroke
Coronary Artery Disease	Hyperthyroidism	Valve Replacement
Depression	Hypothyroidism	Kidney disease

Cancer ______________________ Other ______________________

Flu Vaccine: YES NO Pneumonia Vaccine: YES NO

Past Surgical History: (please list)

____

____

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	

Other ______________________ Do you tan in a tanning salon? Yes No

Do you wear Sunscreen? Yes No If yes, what SPF? __________

Medications: (Please enter all current medications)

____

____

Allergies: (Please enter all allergies)

____

Social History: (please circle one)

Cigarette Smoking: YES NEVER QUIT Alcohol Use: YES NO

Pregnant or planing on pregnancy: YES NO

Family History:

			If yes, which relative(s)
Do you have a family history of Melanoma?	Yes	No	__________
Do you have a family history of Bleeding Disorder?	Yes	No	__________
Do you have a family history of Heart Disease?	Yes	No	__________
Do you have a family history of Diabetes?	Yes	No	__________

Any other family history: ______________________________

Pharmacy:

Name and Address: ______________________________