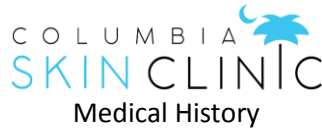


Date: \_\_\_\_\_



**PATIENT:** \_\_\_\_\_  
Last Name First Name Middle Initial Preferred Name

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Reason for your visit today: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

**PREFERRED PHARMACY:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Patient's Past Medical History** (please circle all that apply)

- |                            |                         |                           |
|----------------------------|-------------------------|---------------------------|
| Anxiety                    | Diabetes                | Problems Scarring         |
| Arthritis                  | End Stage Renal Disease | Radiation Treatment       |
| Artificial heart valve     | GERD                    | Seizures                  |
| Artificial joint(s): _____ | Hepatitis               | Stroke                    |
| Asthma                     | High Blood Pressure     | Psychiatric Care          |
| Atrial Fibrillation        | HIV/AIDS                | Pregnant/Breast Feeding   |
| Bleeding Disorders         | High Cholesterol        | Transplant: _____         |
| Cancer: _____              | Hyperthyroidism         | Date: _____               |
| COPD                       | Hypothyroidism          | Trying to become pregnant |
| Coronary Artery Disease    | Pace Maker              | Other: _____              |
| Depression                 | Problems Healing        |                           |

**Surgical History:** \_\_\_\_\_

**Patient's Skin Disease History** (please circle all that apply)

- |                        |                        |                           |
|------------------------|------------------------|---------------------------|
| Acne                   | Eczema                 | Precancerous Moles        |
| Actinic Keratosis      | Flaking or Itchy Scalp | Psoriasis                 |
| Basal Cell Skin Cancer | Hay Fever/Allergies    | Squamous Cell Skin Cancer |
| Blistering Sunburns    | Melanoma               | Other: _____              |
| Dry Skin               | Poison Ivy             |                           |

**Patient's Family History**

Do you have a family history of melanoma? \_\_\_\_\_ If yes, which relative(s)? \_\_\_\_\_

**Medications** (please list all current medications and dosages)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies** (please list all allergies & describe reaction, i.e. hives, anaphylaxis, etc.)

\_\_\_\_\_  
\_\_\_\_\_

**Social History**

- Tobacco use:  non-smoker  current smoker  former smoker
- Drug use:  yes  no
- Alcohol use:  none  less than 1 drink/day  1-2 drinks/day  3+ drinks/day

**Occupation and Place of Employment:** \_\_\_\_\_