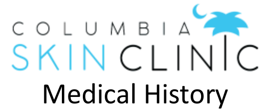
Date: ____________________



Medical History

PATIENT: ____

Last Name *First Name* *Middle Initial* *Preferred Name*

Date of Birth: __/__/___ Email: ____

Primary Care Physician: ____________________________ Referring Physician: ________________________________

PREFERRED PHARMACY: ________________________________ Pharmacy Address: ____________________________

If patient is under the age of 20, please list patient's estimated height and weight: ____________________________________

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

Anxiety	Depression	Pacemaker
Arthritis	Diabetes	Radiation Treatment
Artificial heart valve	End Stage Renal Disease	Seizures
Artificial joint(s): ______________	GERD	Stroke
Asthma	Hepatitis	Psychiatric Care
Atrial Fibrillation	High Blood Pressure	Currently Pregnant/Breast Feeding
Bleeding Disorders	HIV/AIDS	Transplant: __________________
Cancer: _____________________	High Cholesterol	Date: _______________
COPD	Hyperthyroidism	Trying to become pregnant
Coronary Artery Disease	Hypothyroidism	Other: ______________________

Surgical History: ____

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

Acne	Eczema	Psoriasis
Actinic Keratosis	Itchy Scalp	Squamous Cell Skin Cancer
Basal Cell Skin Cancer	Melanoma	Other: ______________________

Do you have a living will?	Y/N	**Do you have a Health Care Proxy?**	Y/N
Do you wear sunscreen?	Y/N	**Do you have a history of tanning salon use?**	Y/N

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: ☐ never smoked ☐ currently smoke ☐ formerly smoked

Occupation and Place of Employment: ____

Rev 12/20