Patient Name: _____ **DOB:** _____ / _____ / _____

Preferred Language: _____ **Race:** _____

Ethnic Group: □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown □ I choose not to specify

Pharmacy (name/town/phone #): _____

Past Medical History: (please circle all that apply)		
• Anxiety • Arthritis • Asthma • Atrial fibrillation • Bone marrow transplant • BPH • Breast cancer • Colon cancer • COPD • Coronary artery disease	• Depression • Diabetes • End stage renal disease • GERD • Head trauma • Hearing loss • Hepatitis • Hypertension • HIV / AIDS • Hypercholesterolemia	• Hyperthyroidism • Hypothyroidism • Leukemia • Lung cancer • Lymphoma • Prostate cancer • Radiation treatment • Seizures • Stroke
Other:		

Past Surgical History: (please circle all that apply)	
• Appendix removed • Bladder removed • Breast Biopsy (right, left, bilateral) • Lumpectomy (right, left, bilateral) • Mastectomy (right, left, bilateral) • Colectomy • Colostomy • Gallbladder removed • Coronary artery bypass • Angioplasty (PTCA) • Biological valve replacement • Mechanical valve replacement • Heart transplant • Hip replacement (right, left, bilateral) • Knee replacement (right, left, bilateral)	• Kidney biopsy • Kidney removed (right, left) • Kidney stone removal • Kidney transplant • Kidney removed • Hepatectomy • Liver transplant • Liver shunt • Ovaries removed: (endometriosis, cancer, cyst) • Pancreas removed • Prostate removed: (cancer, TURP) • Rectal resection • Spleen removed • Testicles removed (right, left, bilateral) • Hysterectomy (fibroids, uterine cancer, cervical cancer)
Other:	

Skin Disease History: (please circle all that apply)		
• Acne • Actinic keratosis • Asthma • Basal cell skin cancer • Blistering sunburns	• Dry skin • Eczema • Flaking/itchy scalp • Hay fever/allergies • Melanoma	• Poison Ivy • Precancerous moles • Psoriasis • Squamous cell skin cancer
Other:		

DO YOU WEAR SUNSCREEN? □ YES □ NO

If yes, what SPF: _____

DO YOU TAN IN A TANNING SALON?

□ YES □ NO

DO YOU HAVE A FAMILY HISTORY OF MALIGNANT MELANOMA?

□ YES □ NO

If yes, which relative(s): _____

MEDICATIONS (please list all current medications):

_____ _____

_____ _____

_____ _____

_____ _____

□ NO MEDICATIONS

DRUG ALLERGIES (please list all known allergies and reactions):

_____ _____

_____ _____

□ NO KNOWN DRUG ALLERGIES

SOCIAL HISTORY:

Smoking status: □ Current every day smoker □ Current someday smoker
□ Former smoker □ Never smoker

Alcohol use: □ None □ < 1 drink per day □ 1-2 drinks per day □ 3 or more drinks per day

Occupation: _____

ALERTS: (please circle all that apply)		
• Allergy to adhesive	• Artificial joint replacement	• MRSA
• Allergy to latex	• Blood thinners	• Pacemaker
• Allergy to lidocaine	• Defibrillator	• Require antibiotics prior to procedure
• Artificial valve replacement	• Keloid scarring	• Rapid heart beat with epinephrine

ARE YOU PREGNANT OR CURRENTLY TRYING TO GET PREGNANT? □ YES □ NO

REVIEW OF SYSTEMS: Are you currently experiencing any of the following? (Please check yes or no)

Symptom	Yes	No
Are you in generally good health?		
Do you have problems with bleeding?		
Do you have problems with healing?		
Do you have problems with scarring?		
Do you currently have a rash?		
Do you have any new skin lesions?		
Do you have any changing skin lesions?		