Patient Name: _____ **DOB:** ___ / ___ / ___ **Date:** ___ / ___ / ___

Marital status: Married/Single/Divorced/Widowed/Separated/Common Law/ Domestic Partner/unknown

Preferred Language: _____ **Race:** _____ (ex. White/African American/Asian)

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

Pharmacy (name/town/phone #): _____

Referring/Primary Care Dr. _____**Last Visit Date**_____

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 List all previous surgeries)

_____

_____

_____

Family History: (please circle all that apply)

- Melanoma — Mom – Dad – Sister – Brother – Daughter – Son
- Non-Melanoma Skin Cancer — Mom – Dad – Sister – Brother – Daughter – Son
- Diabetes — Mom – Dad – Sister – Brother – Daughter – Son
- High-Cholesterol — Mom – Dad – Sister – Brother – Daughter – Son
- High Blood Pressure — Mom – Dad – Sister – Brother – Daughter – Son

Additional Family History:_____

_____

_____

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) what SPF:_____ **DO YOU TAN IN A TANNING SALON? (YES/NO)**

Turn over to complete form

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?		

MEDICATIONS/VITAMINS (please provide current list of medications): ☐ NO MEDICATIONS

Name: _____ **Strength:** _____ **Frequency:** _____
Name: _____ **Strength:** _____ **Frequency:** _____
Name: _____ **Strength:** _____ **Frequency:** _____
Name: _____ **Strength:** _____ **Frequency:** _____
Name: _____ **Strength:** _____ **Frequency:** _____

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 heartbeat with epinephrine

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

1) *Did you receive the flu vaccination this flu season?* ***(YES/NO)***
2) *Are you 65 or older and have received the pneumonia vaccine?* ***(YES/NO)***
3) *Do you have Advance Care Plan?* ***(YES/NO)***

   AND/OR *Who is your surrogate medical decision maker :*

   *Name:*_____ *Phone Number:*_____
4) *Do you have any of the following conditions: (Please circle)*

Coronary Artery Disease (Heart Disease) *Congestive Heart Failure*

Diabetes *Chronic Obstructive Lung Disease(Chronic Bronchitis/ Emphysema)*