Name: Last _____, First _____ Date of Birth:_____/_____/_____

Gender: ☐ Male ☐ Female	**Occupation:**
Primary and / or Referring Physician(s):	
Pharmacy (Name, Street, City):	

Past Medical History (Have you ever had the following:)

☐ Anxiety	☐ End Stage Renal Disease
☐ Arthritis	☐ Hepatitis
☐ Asthma	☐ Hypertension
☐ Atrial Fibrillation	☐ Hypercholesterolemia
☐ Depression	☐ Other:_____
☐ Diabetes	☐ None of the above

Skin Cancer & Atypical Moles (mark if you have had):

☐ Basal Cell Carcinoma	☐ Atypical / Dysplastic Moles
☐ Squamous Cell Carcinoma	☐ Other:_____
☐ Melanoma	

Tobacco Use

☐ Never tobacco smoker	☐ Former tobacco smoker
☐ Smoke tobacco some days	☐ Smoke tobacco every day

Alcohol Consumption

☐ None	☐ Less than 1 drink per day
☐ 1 - 2 drinks per day	☐ 3 or more drinks per day

Review of Symptoms *(mark any current symptom)*

☐ fever or chills	☐ prone to bruising / bleeding
☐ fatigue	☐ delayed wound healing
☐ unintentional weight loss	☐ problems with scars
☐ eye irritation	☐ swollen lymph node
☐ cough	☐ joint pain
☐ shortness of breath	☐ itching
☐ nausea or vomiting	☐ sun sensitivity
☐ abdominal pain	☐ headache

List all known allergies (including medications and symptoms):

Mark if any of the following apply to you:

☐ HIV / AIDS	☐ Pacemaker/Defibrillator
☐ Hepatitis B	☐ Artificial heart valves
☐ Hepatitis C	☐ Artificial joints
☐ Latex Allergy	☐ Internal cancer _____
☐ Organ transplant	☐ Allergy to adhesive
☐ Blood thinners	☐ Allergy to lidocaine
☐ Bleeding disorders	☐ Allergy to topical antibiotics

FOR WOMEN ONLY:

Are you pregnant ☐ Y ☐ N

If yes, expected date of delivery? _____

Are you trying to become pregnant? ☐ Y ☐ N

Are you breastfeeding? ☐ Y ☐ N

Are you on birth control ☐ Y ☐ N Type _____

Do you have regular menstrual cycles? ☐ Y ☐ N

Post-menopausal ☐ Y ☐ N

Hysterectomy ☐ Y ☐ N

Family History

Identify any <u>first-degree</u> relative with the following:

Melanoma
☐ Mother ☐ Father ☐ Sister ☐ Brother

Psoriasis
☐ Mother ☐ Father ☐ Sister ☐ Brother

Asthma, Hay fever, Eczema
☐ Mother ☐ Father ☐ Sister ☐ Brother

Lupus, Rheumatoid Arthritis
☐ Mother ☐ Father ☐ Sister ☐ Brother

Stroke, Heart Attack, High BloodPressure
☐ Mother ☐ Father ☐ Sister ☐ Brother

Inflammatory Bowel (Crohns, Ulcerative Colitis)
☐ Mother ☐ Father ☐ Sister ☐ Brother

Diabetes
☐ Mother ☐ Father ☐ Sister ☐ Brother

List all of the medications you are currently taking:

Associated Skin Care Specialists