



PATIENT NAME _____ DATE _____

PHARMACY _____ PHARMACY PHONE# _____

CURRENT MEDICATIONS

Coumadin Aspirin Plavix Vitamin E Herbal Meds Others(Please List)

ALLERGIES

Aspirin Penicillin Sulfa Codeine Latex Topical Antibiotics Others(Please List)

CHRONIC CONDITIONS

Skin Rashes Arthritis Hypertension Asthma Stroke Epilepsy Diabetes Thyroid Migraines
 Liver Disorder Stomach Disorder Emotional Disorder Heart Disorder Rheumatic Fever Blood Disorder
 Artificial Heart Valve Artificial Joints Mitral Valve Prolapse Pacemaker Defibulator HIV Positive
 Hepatitis C Psoriasis Shingles Fever Blisters Internal Cancer Type _____
 Other _____

SURGICAL HISTORY

Type _____ Date _____
Type _____ Date _____

PERSONAL / FAMILY HISTORY

Indicate any history of skin cancer:

Basal Cell Carcinoma Self Father Mother Brother Sister Grandfather Grandmother
 Squamous Cell Carcinoma Self Father Mother Brother Sister Grandfather Grandmother
 Melanoma Self Father Mother Brother Sister Grandfather Grandmother

SOCIAL HISTORY

If female, are you pregnant? No Yes How many months? _____

Tobacco Use: Current Former Never Unknown

Alcohol Use: Yes No

Type: Cigarettes Other _____

Type: Beer Wine Other _____

Daily Amount: _____

Daily Amount: _____

I certify the above to be true to the best of my knowledge.

_____ Date _____

Signature of Patient or Guardian if Patient is a Minor