PATIENT NAME_____**Date:**_____**Acct. #**_____

Primary Care Physician_____
Address_____
Phone_____

LOCAL PHARMACY INFORMATION

Name: _____

Street/Cross-street: _____

City: _____

Zip code required: _____

Phone #:_____

MAIL ORDER PHARMACY INFORMATION

Name: _____

Street/Cross-street: _____

City: _____

Zip code required: _____

Phone #:_____

Past Medical History:

	Yes	Details
No Pertinent Past Medical History		
Allergic Rhinitis / Seasonal Allergies		
Anemia		
Arthritis		
Asthma		
Autoimmune		
Bleeding Disorder		
Blood Clots		
Breast Cancer		
Cancer		
Depression/ Other Psychiatric Conditions		
Diabetes		
Eye Disease		
Headaches		
Heart Problems		
High Blood Pressure		
Hormone / Fertility Disorders		
Implants / Artificial Joints		
Inflammatory Bowel Disease (Crohn's) Ulcerative Colitis		
Kidney Problems		
Liver Problems		
Lung Problems		
Multiple Sclerosis/Other Neurologic Conditions		
Other		
Pacemaker / Defibrillator		
Pregnancy		
Seizures		
Stomach Problems		
Stroke		
Thyroid Disorder		
Tuberculosis		
Urologic / Prostate Problems		

Past Surgical History:

Surgery	Date	Anesthesia Complications

Past Skin History:	Yes	How Treated	Treatment Date	Diagnosis Date
No Significant Skin History				
Actinic Keratosis (Pre-cancer lesion)				
Basal Cell Carcinoma				
Dysplastic Moles				
Eczema				
Herpes / Cold Sores				
Keloid (Overgrown Scars)				
Lichen Planus				
Lupus/Autoimmune				
Malignant Melanoma				
Psoriasis				
Seborrheic Keratosis				
Squamous Cell Carcinoma				
Tanning Beds				
Urticaria (Hives)				
Vitiligo				
Warts				
Other				

Family History:	Yes	Who?	Notes
Unknown No Relevant Family History			
Adopted/Unknown			
Autoimmune Disorders			
Colon Cancer			
Diabetes			
Glaucoma			
High Blood Pressure			
High Cholesterol			
Liver Disease			
Lung Disease			
Malignant Melanoma			
Obesity			
Premature Coronary Heart Disease			
Skin Cancer			
Thyroid Disease			

Additional Family History:	**Yes**	**Who?**	**Notes**
Abnormal Bleeding			
Abnormal Clotting			
Allergic Rhinitis / Seasonal Allergies			
Asthma			
Brain Tumor			
Breast Cancer			
Depression / Other Psychiatric Conditions			
Eczema			
Endocrine Disease			
Heart Disease			
Hemophilia			
Inflammatory Bowel Disease			
Kidney Disease			
Multiple Sclerosis/Other Neurologic Disorders			
Other			
Other Cancer			
Ovarian Cancer			
Pancreatic Cancer			
Prostate Cancer			
Psoriasis			
Skin Disease			
Von Willebrand			

SOCIAL HISTORY:

ALCOHOL USE ___Do not use ___Socially ____Daily
ILLEGAL DRUGS ___Do not use ___User

SMOKING HISTORY:

___Current every day smoker When started_____ Heavy smoker____
___Current some days smoker When started_____ Light smoker_____
___Former smoker When ended_____
___Never smoked

HEIGHT_____ WEIGHT_____

MEDICATIONS

ALLERGIES
