NAME: _____

REFERRING PHYSICIAN: _____ NUMBER: _____

PRIMARY PHYSICIAN: _____ NUMBER: _____

MEDICATIONS

- ☐ **NOT TAKING ANY MEDICATIONS**
- ☐ ACZONE
- ☐ ASPIRIN
- ☐ CYCLOSPORINE
- ☐ DOXYCYCLINE
- ☐ HYDROXYZINE
- ☐ METFORMIN
- ☐ METHOTREXATE
- ☐ BIOLOGIC THERAPY
- ☐ NOT LISTED: _____
- ☐ BETAMETHASONE
- ☐ CLOBETASOL
- ☐ ELIDEL / PROTOPIC
- ☐ EUCRISA
- ☐ TRUVADA
- ☐ LIPITOR / CRESTOR
- ☐ PREDNISONE
- ☐ ACZONE
- ☐ UVB PHOTOTHERAPY
- ☐ TRIAMCINOLONE
- ☐ TALTZ
- ☐ XELJANZ
- ☐ HYDROCORTISONE
- ☐ SPIRONOLACTONE

IMMUNIZATIONS

- ☐ INFLUENZA
- ☐ PNEUMOCOCAL
- ☐ SHINGLES

ALLERGIES

- ☐ **NO KNOWN DRUG ALLERGIES**
- ☐ PENICILLINS
- ☐ KEFLEX
- ☐ EPINEPHRINE
- ☐ ANTIBIOTIC OINTMENT
- ☐ PREDNISONE
- ☐ LATEX
- ☐ SURGICAL TAPE/ BAND AIDS
- ☐ _____

SKIN DISEASE HISTORY

- ☐ ACTINIC KERATOSIS
- ☐ BASAL CELL CARCINOMA
- ☐ SQUAMOUS CELL CARCINOMA
- ☐ MALIGNANT MELANOMA
- ☐ ACNE
- ☐ ECZEMA
- ☐ PSORIASIS
- ☐ ROSACEA
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

☐ **NO HISTORY NON MELANOMA SKIN CANCER**

☐ **NO HISOTRY OF MELANOMA SKIN CANCER**

FAMILY HISTORY OF NON MELANOMA SKIN CANCER

- ☐ FATHER
- ☐ MOTHER
- ☐ SISTER
- ☐ BROTHER
- ☐ _____
- ☐ UNCLE
- ☐ AUNT
- ☐ GRANDMOTHER
- ☐ GRANDFATHER

FAMILY HISTORY OF MELANOMA SKIN CANCER

- ☐ FATHER
- ☐ MOTHER
- ☐ SISTER
- ☐ BROTHER
- ☐ _____
- ☐ UNCLE
- ☐ AUNT
- ☐ GRANDMOTHER
- ☐ GRANDFATHER

ADVANCED CARE PLANNING - For patients 65 years or older

Do you have a healthcare proxy oor someone who can make medical decisions for you in the event you are unable to?

☐ **YES** ☐ **NO**

_____

NAME

PLEASE SIGN TO ACKNOWLEDGE THAT THE AFOREMENTIONED INFOMRAITON IS TO THE BEST OF YOUR KNOWLEDGE.

_____

PATIENT SIGNATURE *DATE*