History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Hyper - Hypo
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

Other ____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

NONE

Other ____

Do you wear Sunscreen? Yes No
If yes, what SPF? ________
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? ______________________________

Medications: (Please enter all current medications)

____
____
____

Drug Allergies: (Please enter all allergies)

____
____
____

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

ALERTS: (please circle all that apply)

Blood thinners
Defibrillator
Pacemaker
Are you pregnant or currently trying to get pregnant?

Other____

Family History of Skin Cancer, Eczema, Psoriasis or Acne (Only first degree relatives)

____
____
____
____

Preferred Language: ____________________

Race:________________

***Ethnic Group <u>CIRCLE ONE</u> (hispanic or non-hispanic)** (Obama Care Mandated)

Preferred pharmacy Name: ____________________

Phone#: ____________________

City or Zip code:________________

Referring Doctor: ________________________