Name: _____ Date of Birth _____
Preferred Contact Number _____ Date of Visit _____
Are Messages okay to be left at this phone number? Yes No Email Address_____

MEDICAL HISTORY & INTAKE FORM

SKIN DISEASE HISTORY (*Please circle all that apply*)

Acne	Melanoma
Actinic Keratoses	Pigment changes
Asthma	Poison Ivy
Blistering sunburns	Poor healing
Dry or sensitive skin	Psoriasis
Eczema	Rosacea
Flaking or itchy scalp	Scars that overgrow
Hay fever / allergies	Pre-cancerous moles
Basal cell carcinoma	Squamous cell carcinoma

Other _____

Please list your major concerns for your visit today

1. _____

2. _____

3. _____

Do you normally 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 family member(s)? _____

Do you have a **family history of *NON*-Melanoma skin cancer** such as Basal or Squamous cell carcinoma? YES NO
If "YES", which family member(s)? _____

MEDICATIONS (*Please list all current medications or provide a full list*)

_____

_____

ALLERGIES (*Please list all allergies or provide a full list*)

_____

PAST MEDICAL HISTORY (*Please circle all that apply*)

Anxiety	Hepatitis
Arthritis	Hypertension
Artificial Joints	HIV / AIDS
Asthma	Hypercholesterolemia
Atrial Fibrillation	Hyperthyroidism
Bleeding Disorders	Hypothyroidism
Bone Marrow Transplantation	Leukemia
COPD	Lymphoma
Coronary Artery Disease	Radiation Treatment
Depression	Seizures
Diabetes	Stroke
End Stage Renal Disease	Valve Replacement
GERD	Hearing Loss

Cancer (*other than skin*) _____

Other _____

PAST SURGERY HISTORY

NONE

Type of surgery & approximate dates _____

_____

SOCIAL HISTORY

Please choose one:

☐ Non-smoker
☐ Current smoker
☐ Former smoker

Occupation(s) past and/or present _____

☐ Retired – Year _____

Hobbies / Interests _____

Preferred Pharmacy and Location _____