Name: **Appt Date :**

Height: _____ Weight: _____

PAST MEDICAL HISTORY

Do you have a history of, or currently have, any of these conditions? **Please answer yes or no to all questions.**

Skin:

PreCancer/Actinic Keratosis	Y	N
Melanoma	Y	N
Basal cell carcinoma	Y	N
Squamous cell carcinoma	Y	N
Abnormal moles	Y	N
Other skin condition	Y	N

Cardiovascular:

High blood pressure	Y	N
Artificial heart valve	Y	N
Pacemaker/defibrillator	Y	N
High cholesterol	Y	N
Irregular heart rhythm	Y	N
Heart murmur	Y	N

Endocrine:

Diabetes	Y	N
Thyroid disease	Y	N

Hematologic:

Bleeding disorder	Y	N
Blood clotting disorder	Y	N
Lymphoma or leukemia	Y	N

Immunologic / Infections:

AIDS / HIV disease	Y	N
Hepatitis B	Y	N
Hepatitis C	Y	N
Autoimmune disease	Y	N
History of MRSA / Staph	Y	N
Tuberculosis/positive PPD	Y	N
Immunosuppression	Y	N

Neurologic:

Multiple sclerosis	Y	N
Guillain-Barre syndrome	Y	N
Migraines	Y	N
Parkinson's disease	Y	N
Seizures	Y	N
Stroke	Y	N

Psychiatric:

Anxiety disorder	Y	N
Bipolar disease	Y	N
Depression	Y	N

Respiratory:

Asthma	Y	N
Other lung disease	Y	N

Surgical:

Organ transplant	Y	N
Heart surgery	Y	N
Spinal or brain surgery	Y	N
Artificial joint	Y	N

OTHER:

Any kidney problem	Y	N
Arthritis	Y	N
Glaucoma	Y	N
Inflammatory bowel disease	Y	N
Liver disease	Y	N
Reflux (GERD)	Y	N
Stomach ulcers	Y	N
Internal cancer (non-skin)	Y	N
History of radiation	Y	N
Currently attempting to conceive children	Y	N

Females only:

Hysterectomy	Y	N
Tubal ligation	Y	N
Currently pregnant	Y	N
Currently breastfeeding	Y	N

Current Smoker? Y N

Former Smoker? Y N

If yes to smoking, how much and starting /end dates: _____

Alcohol use? Y N

If yes, # times in past year you drank more than 5 (men) or more than 4 (women)? _____

Date of last flu shot: _____

Date of last pneumonia shot: _____

Tanning bed use? Y N

Sunscreen usage? Y N

If yes, sunscreen used: _____

Prior blistering sunburns? Y N

If yes, # of times and dates: _____

Pharmacy: _____

Allergies: _____

_____

_____

Medications (continue on back of this page if needed):

_____

_____

_____

Occupation? _____

Primary Care Provider: _____

Additional Details / Other: _____

FAMILY HISTORY (please circle):

Melanoma Basal cell cancer Squamous cell cancer Psoriasis Eczema Acne