Name: _____ Date of Birth_____/_____/_____

Are you allergic to any medications? □ YES □ NO If yes, list below:

_____

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

_____

_____

Do you have now, or have you ever had: (circle all that apply)

Pacemaker	Organ Transplant	Arthritis	High Blood Pressure
Artificial heart valve	Artificial joint	Kidney Disease	Thyroid Disease
Defibrillator	Reaction to Anesthesia	Lung Disease	Hepatitis/Liver Disease
HIV / AIDS	Allergic Disorders	Eye Disease	Anxiety
Tuberculosis	Bleeding Disorders	Fevers	Depression
Heart Disease	Fainting	Diabetes	Other Cancers

List any other diseases or conditions: _____

List any surgical procedures you have had in the last 6 months:_____

SKIN: Have you ever had skin cancer? □ Yes □ No
Have you ever had melanoma? □ Yes □ No
Do you have a history of any specific skin disease? □ Yes □ No If yes, _____
Do you have problems with healing? □ Yes □ No
Do you develop keloids (scars) after surgery □ Yes □ No
Do you bleed easily? □ Yes □ No
Do you develop skin rashes in reaction to: □ Medications □ Food □ Bandages □Other _____

FAMILY HISTORY: (Please check any of the following medical conditions in your immediate family)

□ Melanoma which relatives?_____ □ Eczema which relatives:? _____
□ Skin Cancer which relatives?_____ □ Hives which relatives?_____
□ Other Cancers which relatives?_____ □ Lupus which relatives?_____
□ Acne which relatives?_____ □ Psoriasis which relatives?_____

SOCIAL HISTORY:

Do you smoke? □ Yes □ No If yes _____ packs per day
Do you drink alcohol? □ Yes □ No If yes _____ drinks per day
Do you go to the tanning bed? □ Yes □ No If yes _____ per month
(Women) Are you pregnant? □ Yes □ No Do you take birth control pills? □Yes □ No

Occupation: _____ Hobbies: _____

Patient Signature: _____ Today's Date: _____/_____/_____

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