Date:_____Patient First and Last Name: _____

Preferred Name:_____If patient is under 18 years old, parent/legal guardian name: _____

Date of Birth: _____ Gender:_____Primary CareDoctor:_____

Pharmacy Name: (Street and city):_____

Emergency Contact:_____Phone Number:_____

If you are 65 years of age or older, is Emergency Contact a Health Care Proxy? ❑Yes ❑No, I do not have one

Medical Conditions: (check all that apply)

❑None	❑Depressive disorder	❑HIV
❑Anxiety disorder	❑Diabetes (Type_____)	❑Hyperthyroidism
❑Arthritis	❑Enlarged Prostate Gland	❑Hypothyroidism
❑Asthma	❑Epilepsy	❑Kidney disease
❑Atrial Fibrillation (Afib)	❑GERD	❑Leukemia
❑Bone Marrow Transplant	❑Hearing loss	❑Lymphoma
❑Cancer: ❑Breast ❑Lung ❑ Colon	❑Heart disease	❑Radiation
❑COPD	❑Hepatitis	Other:_____
❑Stroke	❑High blood pressure	_____

Please list all medications (including vitamins and supplements):

Name: Strength: Frequency:

_____

_____

_____

_____

_____

Allergies and Sensitivites:_____

Skin Disease/Conditions History: (check all that apply)

❑None ❑Acne ❑Actinic Keratoses ❑Basal Cell Carcinoma (Location: _____) ❑Blistering Sunburns

❑Dry Skin ❑Eczema ❑Flaking or Itchy Scalp ❑Hay Fever/Allergies ❑Melanoma (Location: _____)

❑Poison Ivy ❑Precancerous Moles ❑Psoriasis ❑Squamous Cell Carcinoma (Location: _____)

❑ Other:_____

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

Please list all major surgeries: _____

_____

Are you a current smoker? ❑Yes ❑No ❑Former smoker

If yes, which type: ❑Cigarettes ❑Vaping/E-Cigarettes ❑Chewing Tobacco ❑Cigars

How often: ❑Current everyday ❑Current someday

Do you wear sunscreen daily? ❑Yes, SPF:____ ❑No Do you currently use a tanning bed? ❑Yes ❑ No

I have read this questionnaire and disclosed my medical history to the best of my knowledge:

Print Name:_____ Signature:_____