MEDICAL HISTORY

NAME:____**DOB:**______________**AGE:**_______**SEX:**_____

Ht:________ Wt:_______ **PHARMACY NAME /PHONE#:**____

OCCUPATION:______________________________ **EMPLOYER**_____________________________________

EMERGENCY CONTACT NAME/PHONE#):____

PRIMARY CARE PHYSICIAN:____

PCP Address:____

PCP Phone number:_(_______)________________________________

ALLERGIES TO FOOD or MEDICATIONS: 1.___________________ **2.**__________________ **3.**_______________

CURRENT MEDICATIONS: (include Non-prescription medications and Birth Control Pills):

1.____________________________ **4.**____________________________ **7.**____________________________

2.____________________________ **5.**____________________________ **8.**____________________________

3.____________________________ **6.**____________________________ **9.**____________________________

PAST MEDICAL HISTORY (PLEASE CIRCLE):

1.	Anxiety	Yes	No
2.	Arthritis	Yes	No
3.	Asthma	Yes	No
4.	Atrial fibrillation (A Fib)	Yes	No
5.	Cerebrovascular Accident (Stroke)	Yes	No
6.	Artificial joints or heart valve problem	Yes	No
7.	COPD/Emphysema/ lung disease	Yes	No
8.	Coronary Artery Disease or Heart Problems	Yes	No
9.	COVID-19 infection (any type)	Yes	No
10.	Diabetes (Type 1 or 2)	Yes	No
11.	Kidney problems/renal disease	Yes	No
12.	Hypertension (High Blood Pressure)	Yes	No
13.	HIV infection	Yes	No
14.	High Cholesterol	Yes	No
15.	Liver Disease or Hepatitis	Yes	No
16.	Cancer (Other than skin cancer)	Yes	No
17.	Seizures	Yes	No
18.	Bleeding / Clotting Disorder	Yes	No
19.	Autoimmune Disease (Lupus,MS)	Yes	No
20.	Psychiatric Illness (Depression, Bipolar)	Yes	No
21.	Pacemaker or Defibrillator	Yes	No

Other Medical Conditions:________________________________

____

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____

____

List Surgeries (operations)

1.________________________

2.________________________

3.________________________

4.________________________

5.________________________

SKIN CONDITIONS (PLEASE CIRCLE)

1. Acne	Yes	No
2. Actinic Keratosis (Precancer)	Yes	No
3. Basal Cell Carcinoma	Yes	No
4. Eczema	Yes	No
5. H/O Hay Fever	Yes	No
6. Malignant Melanoma	Yes	No
7. Psoriasis	Yes	No
8. Rosacea	Yes	No
9. Squamous Cell Carcinoma	Yes	No
10. Large scars or Keloids	Yes	No

(Continued on Back)

DO YOU HAVE A FAMILY HISTORY OF (PLEASE CIRCLE)

1. Eczema Yes No
2. Hay Fever Yes No
3. Psoriasis Yes No
4. Breast Cancer Yes No
5. Clotting Disorder Yes No
6. Cancer (kind________________) Yes No

FOR WOMEN:

1. Age of first period______________________
2. Are your periods regular:________________
3. Date of last period:_____________________
4. Does your acne flare up around your periods? Yes or No or N/A
5. Have you ever been pregnant? Yes or No
6. How many times have you been pregnant?_______
7. Are you currently pregnant?___________
8. Age of Menopause____________________

HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS: IN THE PAST 3 MONTHS?
(CIRCLE ONE)

1. Persistent Cough: Yes No
2. Shortness of Breath: Yes No
3. Blood Thinners: Yes No
4. Bloody or Dark Stools: Yes No
5. Diarrhea: Yes No
6. Nausea or Vomiting: Yes No
7. Painful Urination: Yes No
8. Blood in urine: Yes No
9. Abdominal Pain: Yes No
10. Arthritis: Yes No
11. Fever: Yes No
12. Persistent Headache: Yes No
13. Visual Changes: Yes No
14. Fatigue: Yes No
15. Muscle Weakness: Yes No
16. Thyroid Problems: Yes No
17. Dizziness or Passed Out: Yes No
18. Night Sweats Yes No

Do you wear Sunscreen? Yes No
If so what SPF_______

Do/did you use tanning beds? Yes No

If so how many years_______

Do you have a family history of Melanoma?
Yes No

Relation to you _____________________

Do you smoke? Yes No
How Much?_______ How Long?________

Do you drink alcohol? Yes No
How much?__________________

Other (please explain)____
____
____
____

____ ____

Patient/Parent Signature **Date** **Physician Signature** **Date**