Medical History

Name:_____ Date of Birth: _____
Pharmacy name:_____ City and street: _____

Select any of the following medical conditions you currently have:

Anxiety	Depression	Hyperthyroidism	Transplant
Arthritis	Diabetes	Hypothyroidism	NONE
Asthma	Kidney Disease	Leukemia	Other
Atrial Fibrillation	GERD	Lung Cancer	_____
BPH	Hearing Loss	Lymphoma	_____
Breast Cancer	Hepatitis	Prostate Cancer	_____
Colon Cancer	Hypertension	Radiation Tx	_____
COPD	HIV / AIDS	Seizures	_____
Coronary Artery Disease	High Cholesterol	Stroke	

Please list any surgeries you have had:

_____
_____

What past skin issues have you had?

_____
_____

Do you wear zinc oxide sunscreen? Yes or No

Have you used tanning beds in past? Yes or No

Do you have a family history of melanoma? Who? _____

Please list all current medications:

_____
_____

Please list medication allergies:

_____
_____

Smoking status (please choose one):

___Current every day smoker ___Former smoker ___Total Years Smoking
___Current occasional smoker ___Never smoker

Alcohol intake:____NONE____1 or >/day____2+ /day____3+/ day

Government required question:

MEN: How many times in the past year have you had more than 5 drinks in a day? _____

WOMEN or ADULTS OVER AGE 65: How many times in the past year have you had more than 4 drinks in a day?

_____

Please indicate any alerts below:	Yes	No
History of Melanoma		
Allergy to adhesive		
Artificial Joints or valves		
Blood thinners		
Pacemaker or other implant		
Lightheaded when giving blood		

Occupation: _____

I attest that I have read and answered all the above questions on both pages.

Signature: _____ Date: _____