

Name:	<u>Physician:</u>
Date:	<u>Location:</u>
	Drug Allergies

MEDICAL HISTORY None Yes (check all that apply)

<input type="checkbox"/> Cataracts	<input type="checkbox"/> Cancer	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Elevated cholesterol	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Elevated triglycerides	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Anemia	<input type="checkbox"/> HIV+/AIDS
<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Peptic Ulcer	<input type="checkbox"/> Nail Disorders
<input type="checkbox"/> Asthma	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Acid Reflux (GERD)	<input type="checkbox"/> Stroke/TIA
<input type="checkbox"/> Organ Transplant	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/>
<input type="checkbox"/> Pregnant	<input type="checkbox"/> Due Date	<input type="checkbox"/> Trying to get Pregnant	

REVIEW OF SYSTEMS None apply Yes (check all that apply)

<input type="checkbox"/> Tendency to scar	<input type="checkbox"/> Daily aspirin/anticoagulant	<input type="checkbox"/> Difficulty with oral antibiotics
<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Immunosuppressed	<input type="checkbox"/> Allergic to antibiotic ointments
<input type="checkbox"/> Pacemaker/Defib	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Allergic to bandages and/or tape
<input type="checkbox"/> Other _____		

CURRENT MEDICATIONS None Yes (list all) See Attached List

PERSONAL HISTORY Skin Cancer: None Yes (list all)

<input type="checkbox"/> Basal cell carcinoma	When? _____	Body Location? _____
<input type="checkbox"/> Squamous cell carcinoma	When? _____	Body Location? _____
<input type="checkbox"/> Melanoma	When? _____	Body Location? _____
Do you have other Skin Problems <input type="checkbox"/> None <input type="checkbox"/> Yes (list all) _____		

FAMILY HISTORY OF SKIN CANCERS No/Unknown Yes (list all)

<input type="checkbox"/> Basal or Squamous cell carcinoma	Relationship? _____
<input type="checkbox"/> Melanoma	Relationship? _____
<input type="checkbox"/> Unknown type of Skin Cancer	Relationship? _____
<input type="checkbox"/> Are there other skin problems in the family <input type="checkbox"/> None <input type="checkbox"/> Yes (list all) _____	

PERSONAL SOCIAL HISTORY None Yes (Check all that apply)

<input type="checkbox"/> Smoke	<input type="checkbox"/> Drink Alcohol	<input type="checkbox"/> Special Diet	<input type="checkbox"/> Regular Exercise	<input type="checkbox"/> Tanning Bed	<input type="checkbox"/> Moderate to severe sun exposure
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OCCUPATION _____

PHARMACY Name _____ Phone Number _____
 Location _____ City _____

FOR OFFICE USE

Init/Date – First Visit:	Init/Date – Follow Up Visits requiring modifications: