

PATIENT MEDICAL HISTORY

Name:	<i>Drug Allergies (Please list above)</i>
Date:	
Acct#:	

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

CURRENT MEDICATIONS None Yes (list all) See Attached List

PERSONAL SKIN 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 None Yes (list all)

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

<input type="checkbox"/> Basal and/or Squamous cell carcinoma	Relationship:
<input type="checkbox"/> Melanoma	Relationship:
<input type="checkbox"/> Unknown type of Skin Cancer	Relationship:

Are there other skin problems in the family None Yes (list all)

PERSONAL SOCIAL HISTORY None Yes (Check all that apply)

Smoke Drink Alcohol Special Diet Regular Exercise Tanning Bed Moderate to severe sun exposure

OCCUPATION

PHARMACY Name _____ Phone Number _____
 Location _____ City _____

FOR OFFICE USE:

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

--	--	--	--	--	--