|  |  |  |
| --- | --- | --- |
| **Patient**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date of Birth**:\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  |  |  |
|  |  |  |  |  |  |  |  |
| **Skin Disease History**: (Please circle all that apply) |  |  |  |
| Acne |  | Dry Skin |  | Poison Ivy |  |  |  |
| A.K.’s (Precancers) | Eczema |  | Precancerous Moles |  |  |
| Asthma |  | Flaking/Itchy Scalp | Psoriasis |  |  |  |
| Basal Cell Cancer | Hay Fever/Allergies | Squamous Cell Skin Cancer |  |
| Blistering Sunburns | Melanoma |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |
| **Do you wear Sunscreen**? : Yes or No | **Do you currently tan in a tanning salon**? Yes or NO |
|  If Yes, what SPF? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Have you ever tanned in a tanning salon**? Yes or NO |
|  |  |  |  |  **Do you have a family history of melanoma**? Yes or No |
|  |  |  |  |  If Yes, what relative(s)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |
| **Allergies**: (Please enter **all allergies, including medication allergies**, and describe what kind of reaction you have/had.) |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |
| **Social History: (Please Circle All that Apply)** |  |  |  |
| **Smoking Status**:  |  |  |  |  |  |  |
| Current Every Day Smoker | Former Smoker |  |  |  |
| Current Some Day Smoker | Never Smoker |  |  |  |
|  |  |  |  |  |
| **Do you drink alcohol**? Yes or No |  |  |  |  |
|  If Yes, how many drinks per day? \_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
|  |  |  |  |  |  |  |  |
| **Have your received a flu shot this year**? Yes or No |  |  |  |
|  If Yes, when was the approximate date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  |  |  |  |  |  |  |  |
| **Have you received a Pneumonia vaccination**? Yes or No |  |  |  |
|  |  |  |  |  |  |  |  |
| **Have you received a Shingles vaccination**? Yes or No |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  | **Flip to the other side to continue** |
|  |  |
| **Are you pregnant or planning a pregnancy?** | **Yes No Not Applicable** |
|  |  |
| **Pharmacy Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Location:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |
| **Current Medications**: (Attach Additional Page if Necessary) |  |  |
| **Medication Name** |  | **Strength** |  | **Dosage** |  |  |
| Example: *Ibuprofen* |  | *200mg* |  | *2 tablets every 8 hours* |
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|   |  |
|   |  |

**Are there any other changes to your medical history that we should know about**?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient or Authorized Representative Signature** **Date**