|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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**