Patient History Form

Name: _____ Date of birth: _____Today's date: _____

Reason for today's visit: _____

Past Medical History

Have you ever had skin cancer: Y N If yes, what type: Basal Squamous Melanoma

Has anyone in your family had skin cancer: Y N
If yes, what type: Basal Squamous Melanoma

Have you or anyone in your family had abnormal moles: Y N

Have you or anyone in your family had keloids: Y N

Do you use tobacco: Y N Do you use alcohol: Y N

Are you pregnant, breastfeeding, or trying to become pregnant: Y N

Heart problems:	Y N	Lung problems:	Y N
Chest pain:	Y N	Diabetes:	Y N
Blood clots:	Y N	Murmur:	Y N
Liver problems:	Y N	Hepatitis:	Y N
Pacemaker:	Y N	Seizures:	Y N
Thyroid problems:	Y N	Kidney problems:	Y N
High Cholesterol:	Y N	Artificial joints:	Y N
Cancer (if yes, list type):_____		HIV/AIDS:	Y N

Allergies: Y N If yes, please list:_____

Medications: Please list or attach a separate list. You may need to call your pharmacy to get the names of medications.

1._____ 2._____3._____
4_____5._____6._____
7._____ ___8._____9._____
10._____11._____12._____

Occupation:_____ Hobbies:_____

Pharmacy Name and Phone Number:_____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true, and accurate.

Patient/Legal Guardian Signature_____