CURRENT MEDICATIONS

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Medication Allergies: _____

Preferred Pharmacy Name:	Pharmacy Phone #:
Pharmacy City or Zip code:	

PAST MEDICAL HISTORY: (please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Breast/Colon/Lung
- ☐ Cancer Bone Marrow
- ☐ Transplant Glaucoma
- ☐ Pacemaker
- ☐ COPD
- ☐ Coronary Arteriosclerosis
- ☐ Depressive Disorder
- ☐ Diabetes
- ☐ Elevated Blood Pressure
- ☐ Kidney Disease
- ☐ Seizures
- ☐ Malignant Tumor _____ (location)
- ☐ Stroke
- ☐ GERD
- ☐ Hearing Loss
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Liver Disease
- ☐ Malignant Tumor of Prostate Radiation Therapy
- ☐ **NONE**

PAST SURGICAL HISTORY:

(Please list any previous surgeries & approximate date or write "none")

DERMATOLOGY HISTORY

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Eczema
- ☐ Basal Cell Carcinoma
- ☐ Squamous Cell Carcinoma
- ☐ Sunburn of Second Degree
- ☐ Malignant Melanoma
- ☐ Scalp itching/flaking
- ☐ Psoriasis
- ☐ Dysplastic Nevus
- ☐ NONE
- ☐ Other _____

Do you wear sunscreen? Yes No	If yes, what SPF?
Do you tan in a tanning salon? Yes No	Do you have a family history of Melanoma?

ALERTS: (please check all that apply)

- ☐ Artificial Joint Replacement
- ☐ Allergy to Topical Antibiotics
- ☐ Rapid heartbeat with epinephrine
- ☐ Pregnant or trying to become Pregnant
- ☐ Blood Thinners
- ☐ Allergy to Adhesive
- ☐ Allergy to Lidocaine
- ☐ Artificial Heart
- ☐ Valve Dementia
- ☐ Require Antibiotics prior to a surgical procedure
- ☐ HIV+
- ☐ Pacemaker
- ☐ Hepatitis C
- ☐ Defibrillator
- ☐ Pacemaker