

REASON FOR TODAY'S VISIT:

ALLERGIES TO MEDICATIONS:

NON-DRUG ALLERGIES (I.E. FOOD, OINTMENTS, ADHESIVE TAPE):

PLEASE LIST YOUR CURRENT MEDICATIONS:

DO YOU NOW HAVE OR HAVE YOU EVER HAD (PLEASE CIRCLE "Y" FOR YES OR "N" FOR NO):

	YES	NO	COMMENTS		YES	NO	COMMENTS
ASTHMA	Y	N	_____	CANCER	Y	N	_____
GLAUCOMA	Y	N	_____	HEPATITIS	Y	N	_____
MELANOMA	Y	N	_____	HEART PROBLEMS	Y	N	_____
SKIN CANCER	Y	N	_____	HIVES OR RASH	Y	N	_____
ECZEMA	Y	N	_____	HIGH BLOOD PRESS	Y	N	_____
PSORIASIS	Y	N	_____	STOMACH PROBLEMS	Y	N	_____
FAINTING SPELLS	Y	N	_____	LUNG DISEASE	Y	N	_____
PACEMAKER	Y	N	_____	LIVER DISEASE	Y	N	_____
DIABETES	Y	N	_____	THYROID DISEASE	Y	N	_____
BLEED EASILY	Y	N	_____	BLOOD THINNERS	Y	N	_____

ANY FAMILY HISTORY OF SKIN CANCER, MELANOMA, DIABETES, SKIN PROBLEMS? Y OR N WHOM?

DO YOU HAVE ANY OTHER MEDICAL PROBLEMS? Y OR N

PLEASE LIST ANY SURGERY

DO YOU SMOKE? YES OR NO IF YES, HOW MANY CIGARETTES PER DAY?

DO YOU DRINK ALCOHOL? YES OR NO IF YES, HOW MUCH DO YOU DRINK PER WEEK?

FEMALE PATIENTS ONLY: ARE YOU PREGNANT? YES OR NO ARE YOU BREAST FEEDING? YES OR NO

DATE OF LAST MENSTRUAL PERIOD:

REVIEWED BY: DR. CONNOLLY

NURSE:

DATE:

UPDATED & REVIEWED ON / / by / / by / / by

UPDATED & REVIEWED ON / / by / / by / / by

UPDATED & REVIEWED ON / / by / / by / / by