Purpose of your Visit: ____

Past Medical History: (please circle or check all that apply)

Anxiety	Coronary Artery Disease	Thyroid Problems (Hyper or Hypo)
Arthritis	Depression	Leukemia
Asthma	Diabetes	Lung Cancer
Atrial fibrillation	End Stage Renal Disease	Lymphoma
Bone Marrow Transplantation	GERD	Prostate Cancer
BPH	**Joint Replacement**	Radiation Treatment
Breast Cancer	Hearing Loss	Seizures
CHF	**Heart Valve replacement**	Stroke
Colon Cancer	**Hepatitis/HIV/AIDS**	**Pacemaker/Defibrillator**
COPD	High Blood pressure	NONE____ OTHER_________
	High Cholesterol	

Past Surgical History:

____

Skin Disease History: (please circle or check all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	NONE____ OTHER______

Family History (please circle all that apply)

Melanoma Mother Father Sister Brother Daughter Son Other

Did you receive the Flu Vaccine this past flu season? YES or NO
Have you ever received the pneumonia vaccine? YES or NO

Medications: (Please enter all current medications or attach a current list)

____

____

Allergies: (Please enter all allergies)____

Cigarette Smoking:
- Never Smoked ____
- Quit: Former Smoker___
- Smokes Less than 1 daily___
- Smokes daily___

Alcohol Intake:
- None_____
- Less than one drink____
- 1-2 drinks daily____
- 3 or more drinks daily____

Do you have any of the following:
- problems with bleeding____
- problems with healing____
- problems with scarring____

Do You Have a Living Will? YES___No___ If so, who is your surrogate? Name____________________________

Pharmacy Name:______________________________
Address______________________________Phone#______________
Mail Order Pharmacy______________________ Mail order#______________
Primary Care Physician Name______________________________
Address______________________________Phone#______________
When did you see last see your primary physician? Month____ Year____