

Medical History Form

Patient Name: _____ **DOB:** _____ **Date:** _____

Pharmacy (name/town/phone #): _____

Primary Care or Referring Physician: _____

Past Medical History: (please circle all that apply)		
<ul style="list-style-type: none"> • Anxiety • Arthritis • Asthma • Atrial fibrillation • Bone marrow transplant • BPH • Breast cancer • Colon cancer • COPD • Coronary artery disease 	<ul style="list-style-type: none"> • Depression • Diabetes • End stage renal disease • GERD • Head trauma • Hearing loss • Hepatitis • Hypertension • HIV / AIDS • Hypercholesterolemia 	<ul style="list-style-type: none"> • Hyperthyroidism • Hypothyroidism • Leukemia • Lung cancer • Lymphoma • Prostate cancer • Radiation treatment • Seizures • Stroke
Other: _____		

Past Surgical History: (please circle all that apply)	
<ul style="list-style-type: none"> • Appendix removed • Bladder removed • Breast Biopsy (right, left, bilateral) • Lumpectomy (right, left, bilateral) • Mastectomy (right, left, bilateral) • Colectomy • Colostomy • Gallbladder removed • Coronary artery bypass • Angioplasty (PTCA) • Biological valve replacement • Mechanical valve replacement • Heart transplant • Hip replacement (right, left, bilateral) • Knee replacement (right, left, bilateral) 	<ul style="list-style-type: none"> • Kidney biopsy • Kidney removed (right, left) • Kidney stone removal • Kidney transplant • Kidney removed • Hepatectomy • Liver transplant • Liver shunt • Ovaries removed: (endometriosis, cancer, cyst) • Pancreas removed • Prostate removed: (cancer, TURP) • Rectal resection • Spleen removed • Testicles removed (right, left, bilateral) • Hysterectomy (fibroids, uterine cancer, cervical cancer)
Other: _____	

Skin Disease History: (please circle all that apply)		
<ul style="list-style-type: none"> • Acne • Actinic keratosis • Asthma • Basal cell skin cancer • Blistering sunburns 	<ul style="list-style-type: none"> • Dry skin • Eczema • Flaking/itchy scalp • Hay fever/allergies • Melanoma 	<ul style="list-style-type: none"> • Poison Ivy • Precancerous moles • Psoriasis • Squamous cell skin cancer
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 MALIGNANT MELANOMA?
 YES NO
If yes, which relative(s): _____

****ALSO, PLEASE COMPLETE THE INFORMATION ON THE BACK OF THIS FORM****

