Medical History Form

Patient Name: ______________________________ **DOB:** __________________ **Date:**_________________

Pharmacy **(name/town/phone #):** ____

Primary Care/Referring Physician:____ **Check if NO PCP** ☐

Past Medical History: (please circle all that apply)

• Anxiety	• Depression	• Hyperthyroidism
• Arthritis	• Diabetes	• Hypothyroidism
• Asthma	• End stage renal disease	• Leukemia
• Atrial fibrillation	• GERD	• Lung cancer
• Bone marrow transplant	• Head trauma	• Lymphoma
• BPH	• Hearing loss	• Prostate cancer
• Breast cancer	• Hepatitis	• Radiation treatment
• Colon cancer	• Hypertension	• Seizures
• COPD	• HIV / AIDS	• Stroke
• Coronary artery disease	• Hypercholesterolemia	

Other:

Past Surgical History: (please circle all that apply)

• Appendix removed	• Kidney biopsy
• Bladder removed	• Kidney removed (right, left)
• Breast Biopsy (right, left, bilateral)	• Kidney stone removal
• Lumpectomy (right, left, bilateral)	• Kidney transplant
• Mastectomy (right, left, bilateral)	• Kidney removed
• Colectomy	• Hepatectomy
• Colostomy	• Liver transplant
• Gallbladder removed	• Liver shunt
• Coronary artery bypass	• Ovaries removed: (endometriosis, cancer, cyst)
• Angioplasty (PTCA)	• Pancreas removed
• Biological valve replacement	• Prostate removed: (cancer, TURP)
• Mechanical valve replacement	• Rectal resection
• Heart transplant	• Spleen removed
• Hip replacement (right, left, bilateral)	• Testicles removed (right, left, bilateral)
• Knee replacement (right, left, bilateral)	• Hysterectomy (fibroids, uterine cancer, cervical cancer)

Other:

Skin Disease History: (please circle all that apply)

• Acne	• Dry skin	• Poison Ivy
• Actinic keratosis	• Eczema	• Precancerous moles
• Asthma	• Flaking/itchy scalp	• Psoriasis
• Basal cell skin cancer	• Hay fever/allergies	• Squamous cell skin cancer
• Blistering sunburns	• Melanoma	

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****

MEDICATIONS (please list all current medications):

____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

☐NO MEDICATIONS

DRUG ALLERGIES (please list all known allergies and reactions):

____________________	____________________

☐NO KNOWN DRUG ALLERGIES

SOCIAL HISTORY:

Smoking status: ☐Current every day smoker ☐Current someday smoker ☐Former smoker ☐Never smoker

Alcohol use: ☐None ☐< 1 drink per day ☐1-2 drinks per day ☐3 or more drinks per day

Occupation: ____

If you are 65 or older, have you had the pneumonia vaccination? ☐ **Yes** ☐**No**

ALERTS: (please circle all that apply)		
• Allergy to adhesive • Allergy to latex • Allergy to lidocaine • Allergy to topical antibiotic ointments • Bloodthinners	• Breastfeeding • Defibrillator • Fainting • Immunosuppression • Keloid Scarring	• MRSA • Pacemaker • Rapid heartbeat with epinephrine • Pregnancy • Planning pregnancy

REVIEW OF SYSTEMS: Are you currently experiencing any of the following? (Please check yes or no)

Symptom	Yes	No
Are you in generally good health?		
Do you have problems with bleeding?		
Do you have problems with healing?		
Do you have problems with scarring?		
Do you currently have a rash?		
Do you have any new skin lesions?		
Do you have any changing skin lesions?		