This Form will need to be updated yearly.
Name_____ Date of Birth _____Today's Date_____
Choice of Pharmacy_____ Pharmacy Address_____

Past Medical History: Select any of the following medical conditions that you ***currently*** have:	
__ Anxiety	__ Hearing Loss
__ Arthritis	__ Hepatitis
__ Asthma	__ Hypertension (High blood Pressure)
__ Artrial Fibrillation(Irregular Heartbeat)	___HIV/ AIDS
___Bone Marrow Transplant	__ Hypercholesterolemia
___BPH (enlarged Prostate)	__ Hyperthyroidism
__ Breast Cancer	__Hypothyroidism
__ Colon Cancer	__Leukemia
__ COPD (Emphysema)	__Lung Cancer
__ Coronary Artery Disease	__ Lymphoma
__Depression	__Prostate Cancer
__Diabetes	__ Radiation Treatment
__ End Stage Renal Disease	___Seizures
__ GERD (Acid Reflux)	__ Stroke
	__ Other:_____
	_____
	_____
	__None

Past Surgeries: Have you had any surgeries on the following organs:	
__ Appendix (Appendectomy)	__ Kidney: Kidney Stone Removal
__ Bladder (Cystectomy)	__ Kidney: Kidney Transplant
__ Breast: Breast Biopsy	__ Kidney: Nephrectomy
__ Breast: Lumpectomy (Both Breast)	__ Liver: Hepatectomy
__ Breast: Lumpectomy (Left Breast)	__ Liver: Liver Transplant
__ Breast: Lumpectomy (Right Breast)	__ Liver: Shunt
__ Breast: Mastectomy (Both Breast)	__ Ovaries (Oophorectomy): Endometriosis
__ Breast: Mastectomy (Left Breast)	__ Ovaries (Oophorectomy): Ovarian Cancer
__ Breast: Mastectomy: (Right Breast)	__ Ovaries (Oophorectomry): Ovarian Cyst
__ Colon (Colectomy): Colon Cancer Resection	__ Ovaries: Tubal Ligation
__ Colon (Colectomy): Diverticulitis	__ Pancreas: Pancreatectomy
__ Colon (Colectomy): Inflammatory Bowel Disease	__ Prostate: (Prostatectomy): Prostate Biopsy
__ Colon: Colostomy	__ Prostate: (Prostatectomy) : TURP
__ Colon: Colonoscopy	__ Rectum: APR
__ Gallbladder (Cholecystectomy)	__ Rectum: Low Anterior Resection
__ Heart: Biological Valve Replacement	__ Skin: Basal Cell Carcinoma
__ Heart: Coronary Artery Bypass Surgery	__ Skin: Melanoma
__ Heart: Heart Transplant	__ Skin: Skin Biopsy
__ Heart: Mechanical Valve Replacement	__ Skin: Squamous Cell Carcinoma
__ Heart: PTCA	__ Spleen (splenectomy)
__ Joint Replacement: Hip (Both)	__ Testicles (Orchiectomy)
__ Joint Replacement: Hip (Left)	__ Uterus (Hysterectomy): Fibroids
__ Joint Replacement: Hip (Right)	__ Uterus (Hysterectomy) Uterine Cancer
__ Joint Replacement: Knee (Both)	__ Uterus (Hysterectomy): Cervical Cancer
__ Joint Replacement: Knee (Left)	__ Other:_____
__ Joint Replacement: Knee (Right)	_____
__ Kidney: Kidney Biopsy	_____
	__None

Please fill out front and back. **Continue→**

Skin Disease History: Have you had any of the following skin conditions: __Acne __Actinic Keratoses (precancer) __Asthma __Basal Cell Skin Cancer __Blistering Sunburns __Dry Skin __Eczema	__Flaking or Itchy Scalp __Hay Fever/Allergies __Melanoma __Poison Ivy __Dysplastic/ Precancerous Moles __Psoriasis __Squamous Cell Cancer __ Other:_____ _____ _____ __None

Do you wear sunscreen? __ no __yes If yes, what SPF?___

Do you tan in a tanning Salon? __no __yes

Do you have a family history of Non Melanoma (Basal Cell Carcinoma, Squamous cell Carcinoma)?
__no __yes
If yes, which relatives?_____

Do you have a family history of Melanoma? __no __yes
If yes, which relatives?_____

Medications: __None			
Name	Strength	Dose(how many pills)	Frequency(how often)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Allergies: __None	
Allergic to the following medications:	Reaction
1.	
2.	
3.	
4.	
5.	

Do you smoke? __ Never __Occasionally __ Everyday __I quit ___ years ago

Do you Drink Alcohol? __Never __Less than 1 drink per day __1-2 drinks per day __ 3+ drinks per day

Occupation: _____

Please fill out front and back.

Continue→