Medical History

Patient Name: _____ Date of birth: _____
Reason for today's visit: _____
Primary care physician & physician phone:_____
What is your preferred pharmacy: _____

Do you have any of the following: (please mark all that apply)
COPD ☐ Heart Failure ☐
Coronary Artery Disease ☐ Diabetes ☐

If YES, who is your Physician & when was your last visit:_____

Please list any skin conditions below:

Do you have a family history of Melanoma?
Yes ☐ No ☐ If yes, which relative(s)? _____

Cigarette Smoking:
Never smoked ☐
Quit: former smoker ☐
Smokes less than daily ☐
Smokes daily ☐

Alcohol Use (per day):
None ☐
<1, 1 ,2, 3, 4, 5+
☐☐☐☐☐☐

Medications:

Name of Drug	Dosage	Frequency

Drug Allergies:

Women: Are you pregnant, nursing, or planning to become pregnant? ☐Yes No☐

In Case of Emergency, whom should we notify?
Name: _____ Relationship: _____
Phone (____)_____

_____ _____
Patient or Guardian Signature **Date**