

Patient Name: _____

Date of Birth: _____

Past Medical History (patient): (please check all that apply)

- Actinic Keratosis
- Allergies
- Anemia
- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- Bleeding disorder
- Blood clots
- Cancers _____
- Chronic infection
- COPD
- CVA (stroke)
- Depression
- Diabetes
- Eczema
- GERD
- Glaucoma
- Graves Disease
- Headaches
- Heart disease/CAD
- Hepatitis C
- High cholesterol
- Hypertension
- Hyperthyroidism
- Hypothyroidism
- Irregular heart rate
- Kidney disorder
- Liver Disease
- Mental disorder
- Multiple Sclerosis
- Otosclerosis
- Psoriasis
- Rosacea
- Seizure disorder
- Sleep Apnea
- Thyroid disease
- Tinnitus
- Tuberculosis
- Vertigo

Do you have history of skin cancer? YES NO

Past Surgical History: (please list with date)

Social History:

Do you smoke cigarettes? Current Never In the past #packs/day _____ #years _____

Do you use recreational drugs? Yes No Type: _____

Do you drink alcohol? Yes No # drinks/week _____

Do you drink caffeine? Yes No # drinks/day _____

Are you currently pregnant? Yes No

Are you currently breast feeding? Yes No

Recent changes in your sleep pattern? Yes No

Marital Status: Single Married Divorced Separated Widowed Partnered

Do you have children? Yes No

Occupation: _____

Family History:

Abnormal moles	<input type="checkbox"/> No	<input type="checkbox"/> Yes	relative: _____	Hepatitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	relative: _____
Allergies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	relative: _____	High Cholesterol	<input type="checkbox"/> No	<input type="checkbox"/> Yes	relative: _____
Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	relative: _____	Hypertension	<input type="checkbox"/> No	<input type="checkbox"/> Yes	relative: _____
Autoimmune disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	relative: _____	Keloids	<input type="checkbox"/> No	<input type="checkbox"/> Yes	relative: _____
Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	relative: _____	Migraines	<input type="checkbox"/> No	<input type="checkbox"/> Yes	relative: _____
COPD	<input type="checkbox"/> No	<input type="checkbox"/> Yes	relative: _____	Otitis Media- chronic	<input type="checkbox"/> No	<input type="checkbox"/> Yes	relative: _____
Depression	<input type="checkbox"/> No	<input type="checkbox"/> Yes	relative: _____	Otosclerosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	relative: _____
Dermatitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	relative: _____	Psoriasis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	relative: _____
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	relative: _____	Rosacea	<input type="checkbox"/> No	<input type="checkbox"/> Yes	relative: _____
Eczema	<input type="checkbox"/> No	<input type="checkbox"/> Yes	relative: _____	Seizure disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes	relative: _____
Hearing disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes	relative: _____	Thyroid disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	relative: _____

Family history of skin cancer? YES NO

Medications: Do you take any prescription/non-prescription medications or supplements? No Yes (please list)

Allergies: Do you have any allergies or sensitivities to medications that you know of? No Yes (please list)

Patient Signature: _____

Date: _____