

PATIENT NAME: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

Pharmacy Zip: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Pharmacy phone #: \_\_\_\_\_

Primary Doctor: \_\_\_\_\_

**Past Medical History:** (please circle all that apply)

- |                             |                         |                     |
|-----------------------------|-------------------------|---------------------|
| Anxiety                     | Diabetes                | Leukemia            |
| Arthritis                   | End Stage Renal Disease | Lung Cancer         |
| Asthma                      | GERD (Reflux Disease)   | Lymphoma            |
| Atrial fibrillation         | Hearing Loss            | Pacemaker           |
| Bone Marrow Transplantation | Hepatitis               | Prostate Cancer     |
| Breast Cancer               | Hypertension            | Radiation Treatment |
| Colon Cancer                | HIV/AIDS                | Seizures            |
| COPD                        | Hypercholesterolemia    | Stroke              |
| Coronary Artery Disease     | Hyperthyroidism         |                     |
| Depression                  | Hypothyroidism          |                     |
| Other _____                 |                         |                     |

**Past Surgical History:** (please circle all that apply)

- |                                   |                                     |                         |
|-----------------------------------|-------------------------------------|-------------------------|
| Artificial joints                 | Heart: Biological Valve Replacement | Ovaries: Endometriosis  |
| Colon Cancer Resection            | Joint Replacement                   | Ovarian Cancer          |
| Colon: Inflammatory Bowel Disease | Kidney Removed (Nephrectomy)        | Ovaries: Tubal Ligation |
| Defibrillator                     | Loop recorder                       | Prostate Cancer         |
| Heart: Coronary Artery Bypass     | Mastectomy (Right, Left, Bilateral) | Stents                  |
| Heart: PTCA/Stent                 | Organ Transplant                    | Uterine/Cervical Cancer |
| Other _____                       |                                     |                         |

**Skin Disease History:** (please circle all that apply)

- |                        |                        |                           |
|------------------------|------------------------|---------------------------|
| Acne                   | Blistering Sunburns    | Hay Fever/Allergies       |
| Actinic Keratoses      | Dry Skin               | Melanoma                  |
| Asthma                 | Eczema                 | Precancerous Moles        |
| Basal Cell Skin Cancer | Flaking or Itchy Scalp | Psoriasis                 |
| Other _____            |                        | Squamous Cell Skin Cancer |

Do you have a family history of melanoma?      Yes      No      If yes, which relative(s)? \_\_\_\_\_

Any other family history: \_\_\_\_\_

**Medications:** (please enter all current medications)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies:** (please enter all allergies)

\_\_\_\_\_

**Social History:** (please circle all that apply)

- |                    |              |                     |                    |                          |
|--------------------|--------------|---------------------|--------------------|--------------------------|
| Cigarette smoking: | Never smoked | Quit: former smoker | Current: every day | Current: some days       |
| Alcohol use:       | None         | < 1 drink per day   | 1-2 drinks per day | 3 or more drinks per day |

**Occupation and Workplace:** \_\_\_\_\_