Medical History

Name: _____ Date of Birth: _____
Pharmacy name: _____ City and street: _____
EMA MRN: _____ Referring Physician: _____

Select any of the following medical conditions you currently have:

Anxiety	Depression	Hyperthyroidism	Transplant
Arthritis	Diabetes	Hypothyroidism	NONE
Asthma	Kidney Disease	Leukemia	Other
Atrial Fibrillation	GERD	Lung Cancer	_____
BPH	Hearing Loss	Lymphoma	_____
Breast Cancer	Hepatitis	Prostate Cancer	_____
Colon Cancer	Hypertension	Radiation Tx	_____
COPD	HIV / AIDS	Seizures	_____
Coronary Artery Disease	High Cholesterol	Stroke	

Please list any surgeries you have had:

_____
_____

What past skin issues have you had?

_____
_____

Do you wear zinc oxide sunscreen? Yes or No

Have you used tanning beds in past? Yes or No

Do you have a family history of melanoma? Who? _____

Please list all current medications:

_____
_____

Please list medication allergies:

_____
_____

Date of last flu shot:_____
Date of last pneumonia shot:_____

Smoking status (please choose one):

___ Current every day smoker
___ Current occasional smoker
___ Former smoker
___ Never smoker
___ Total Years Smoking

Alcohol intake: ___ NONE ___1 or >/day ___2+ /day ___3+/ day

Government required question:

MEN: How many times in the past year have you had more than 5 drinks in a day? _____

WOMEN or ADULTS OVER AGE 65: How many times in the past year have you had more than 4 drinks in a day? _____

Please indicate any alerts below:	Yes	No
History of Melanoma		
Allergy to adhesive		
Artificial Joints or valves		
Blood thinners		
Pacemaker or other implant		
Lightheaded when giving blood		

Please indicate any current symptoms:	Yes	No
Fever or Chills		
Problems with bleeding		
Problems with healing		
Abnormal scarring		
Rash		
Suppressed immune system		
Hay Fever		
Chest Pain		
Night Sweats		
Unintentional Weight Loss		
Thyroid Problems		
Sore throat		
Blurry vision		
Abdominal cramps or pain		
Blood stool		
Blood in urine		
Joint aches		
Muscle weakness		
Neck stiffness		
Headaches		
Seizures		
Cough or Shortness of Breath		
Wheezing		
Anxiety		
Depression		

I attest that I have read and answered all the above questions on both pages.

Signature: _____ Date: _____