**HEALTH HISTORY**

Today’s Date\_\_\_\_\_\_\_\_\_\_

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Last Name First Name M.I. Date of Birth\_\_\_\_\_\_\_\_\_\_

**Preferred Language\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Race**  **Location (Town)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Ethnic Group** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History**

Melanoma Y N

Non-Melanoma Skin Cancer Y N

Artificial Heart Valve Y N

Artificial Joint Y N

Organ Transplant Y N

Pacemaker/Defibrillator

**Family History**

Melanoma Y N If yes, relation to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Do you smoke? Y N If yes, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you ever smoke? Y

Do you use alcohol? Y N

**Femail Patients**

Are you currently using birth control pills?

Are you pregnant?

Are you currently planning a pregnancy?

\**Please advise the doctor if you are currently pregnant, planning a pregnancy, or sexually active without using contraceptives \**

**List All Medication (Please Include Dosages or Attach Medication List)**

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**Are You Allergic to Any Medications?** Y N

If yes, please list.

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Signature of Patient or Parent