HEALTH HISTORY

_____ _____
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	Y	N

Other: _____

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	N	
Do you use alcohol?	Y	N	

Female Patients

Are you currently using birth control pills?	Y	N
Are you pregnant?	Y	N
Are you currently planning a pregnancy?	Y	N

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

<u>List All Medication</u> (Please Include Dosages or Attach Medication List)

_____

_____

_____

<u>Are You Allergic to Any Medications</u>? Y N
If yes, please list.

_____ _____

Signature of Patient or Parent Today's Date