HEALTH HISTORY

_____ _____

Last Name First Name Middle Initial Date of Birth

Preferred Language: _____ Pharmacy Name: _____

Race: _____ Location (Town): _____

Ethnic Group: _____

Past Medical History *(Please Circle)*

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 *(Please Circle)*

Melanoma Y N If yes, relation to patient:_____

Social History *(Please Circle)*

Do you smoke? Y N If yes, how much? _____

Did you ever smoke? Y N

Do you use alcohol? Y N

Female Patients *(Please Circle)*

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 is you are currently pregnant, planning a pregnancy, or sexually active without using contraceptives

List all Medications (Please Include Dosages or Attach Medication List)

_____

_____

_____

Are you allergic to any medications? *(Please Circle)* Y N

If yes, please list: _____

_____ _____

Signature of Patient or Parent/Guardian Today's Date