## **HEALTH HISTORY**

Last Name F	First Name			Midd	dle Initia	<u> </u>	Date of Birth
Preferred Language:				_	Phar	macy Na	ame:
Race:				Location (Town):			
Ethnic Group:				_			
Past Medical History (	'Pleas	e Cir	cle)				
Melanoma		Υ	N			Heiah	nt:
Non-Melanoma Skin Ca	ancer	=	N				
			N				
Artificial Joint			N			Weig	ht:
Organ Transplant			N			, voig	
Pacemaker/Defibrillator		Y	N				
Other:							
Family History (Please	e Circl	e)					
Melanoma		Υ	N	If ye	s, relatio	on to pat	ient:
Social History (Please	Circle	e)					
Do you smoke?		Υ	Ν	If ye	s, how r	nuch? _	
Did you ever smoke?		Υ	Ν				
Do you use alcohol?		Υ	N				
Reproductive History	(Plea	se Ci	rcle)				
Are you currently using birth control pills?					Ν	N/A	
Are you pregnant?				Υ	Ν	N/A	
Are you currently planning a pregnancy?  *Please advise the doctor is you are currently pregnant, pla						N/A or sexuall	y active without using contraceptives*
List all Medications (P							
Are you allergic to any r	medic	ation	s? (Plea	ıse Cir	rcle)	Y	N
If yes, please list:							
<del></del>							<del></del>
Signature of Patient or I	Paren	t/Gua			Today's Date		