

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	Height: _____
Non-Melanoma Skin Cancer	Y	N	
Artificial Heart Valve	Y	N	Weight: _____
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: _____
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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	

Reproductive History (Please Circle)

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

Please advise the doctor if 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