PLEASE FILL OUT ALL MEDICAL HISTORY BELOW PRIOR TO SEEING YOUR PHYSICIAN

Patient's name____ **Today's date**____________________________________
Reason for today's visit____
Pharmacy's name____ **Pharmacy's phone number**________________________
How often do you drink alcohol? NEVER / SOCIALLY / DAILY **Do you smoke?** YES / NO

DRUG ALLERGIES (including local anesthetic and adhesives)

____
____
____

CURRENT MEDICATIONS (including over-the-counter and nutritional supplements; e.g. aspirin, vitamin E, fish oil)

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____
____

MEDICAL HISTORY (please check all that apply)

- ☐ Acid Reflux
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Autoimmune type___________________________________
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Kidney Condition
- ☐ Liver Condition
- ☐ Peptic Ulcer
- ☐ Periodontal Disease
- ☐ Other____
- ☐ Thyroid Condition
- ☐ Tuberculosis

SKIN CANCER HISTORY
Do you have a past history of skin cancer? YES / NO
If yes, please list diagnosis and treatments

	Year

Has anyone in your immediate family had a skin cancer? YES / NO
If yes, please list relation to the person and their diagnosis

COSMETIC HISTORY
Have you ever had cosmetic facial surgery, injections or laser treatments? YES / NO
If yes, please list treatments

	Year

FEMALE PATIENTS ONLY
Are you pregnant or trying to become pregnant? YES / NO
Are you currently using any forms of birth control? YES / NO
If yes, please list birth control type
