Date: _____
MRN: _____

Medical History

Name: _____ **Date of Birth:** _____

Best contact number to reach you during office hours: _____

Pharmacy: _____

Reason for visit: _____

How long have you had this problem? _____

What treatment have you used on your own? _____

What prescription treatments have been used? _____

Did a doctor refer you to us? ___ **If yes, name of doctor:** _____

Current Medications (including over the counter supplements):

1)	**8)**
2)	**9)**
3)	**10)**
4)	**11)**
5)	**12)**
6)	**13)**
7)	**14)**

Medication allergies: _____

Medical History:

(Women) Are you pregnant? Y N If yes, due date: _____

Test positive for HIV/AIDS? Y N Hepatitis? Y N

Skin Cancer History (please circle one):

Basal cell carcinoma Y N Squamous cell carcinoma Y N Melanoma Y N

If yes, year last skin cancer treated_____

Family History:

Mom, dad, aunt, uncle, or siblings with history of (circle one):

Basal cell carcinoma? Y N Squamous cell carcinoma? Y N Melanoma? Y N

Social History:

Occupation/School: _____

Smoking history (Circle one) never a smoker former smoker current smoker