NAME _____ Date of Birth: _____

1. Do you have any of the following medical problems (check all that apply)?

- Anxiety
- Arthritis
- Asthma
- Atrial fibrillation
- Bone marrow transplant
- BPH (prostate enlargement)
- Breast cancer
- Colon cancer
- Coronary artery disease
- Depression
- Diabetes
- End stage renal disease
- GERD (GI/reflux)
- Hearing loss
- Hepatitis (liver disease)
- Hypertension (high blood pressure)
- HIV/AIDS
- Hypercholesterolemia (high cholesterol)
- Hyperthyroidism (overactive thyroid)
- Hypothyroidism (underactive thyroid)
- Leukemia (blood cancer)
- Lung cancer
- Lymphoma
- Prostate cancer
- Radiation treatment
- Seizures
- Stroke
- Other: _____
- No known past medical problems

2. What surgeries have you had?

_____
_____
_____
_____

_____
_____

3. Do you have any of the following skin problems (please check all that apply)?

- Acne
- Actinic keratoses (precancerous lesions)
- Asthma
- Basal cell skin cancer
- Blistering sunburns
- Dry skin
- Eczema
- Flaking or itchy scalp
- Hay fever/Allergies
- Melanoma
- Poison ivy
- Precancerous moles
- Psoriasis
- Squamous cell skin cancer
- Other: _____
- No known skin issues

4. Do you wear sunscreen?

- Yes – What SPF? _____
- No

5. Do you tan in a tanning salon?

- Yes
- No

6. Has anyone in your family had melanoma? (NOT Basal Cell or Squamous Cell)

- Yes – Who? _____
- No

7. What medications do you take?

_____
_____
_____
_____
_____

NAME _____ Date of Birth: _____

_____

8. Do you have any medication allergies?

- Yes – Please list: _____
- No

9. Have you ever smoked cigarettes or other tobacco products?

- No, never
- Yes, but not anymore
  - Total years you smoked? ___
  - How many packs per day? ___
- Yes, currently

10. Do you use drugs?

- Yes
- No

11. How much alcohol do you drink?

- None
- Less than 1 drink per day
- 1 – 2 drinks per day
- 3 or more drinks per day

12. What is your occupation?

_____

13. Who has the following medical problems in your family?
(include: children, parents, grandparents, siblings, aunts and uncles)

Psoriasis_____
Eczema _____
Skin cancer _____
Pancreatic cancer _____
Lung cancer _____
Other cancer _____
Thyroid problem _____
Diabetes_____
Rheumatoid arthritis _____
Heart disease _____
Hair loss _____
Other _____

Review of Systems: Do you have any of the following (please check all that apply)?

- Problems with bleeding
- Problems with healing
- Problems with scarring (hypertrophic or keloid)
- Rash
- Immunosuppression
- Hay fever
- Chest pain
- Fever or chills
- Night sweats
- Unintentional weight loss
- Thyroid problems
- Sore throat
- Blurry vision
- Abdominal pain
- Bloody stool
- Bloody urine
- Joint aches
- Muscle weakness
- Neck stiffness
- Headaches
- Other: _____
- NONE