

PAST MEDICAL HISTORY: *(please indicate all that apply)*

- | | | |
|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> High Blood pressure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Transplantation | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> NONE |

PAST SURGERIES:

- | | |
|---|--|
| <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Skin: Melanoma |
| <input type="checkbox"/> Heart transplant | <input type="checkbox"/> Skin: Squamous Cell Carcinoma |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Kidney Transplant | |
| <input type="checkbox"/> Skin: Basal Cell Carcinoma | |

SKIN DISEASE HISTORY: *(please indicate all that apply)*

- | | | |
|---|--|--------------------------------|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Other |
| <input type="checkbox"/> Actinic Keratoses | <input type="checkbox"/> Hay Fever/Allergies | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Melanoma | _____ |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Poison oak | |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Precancerous Moles | |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Psoriasis | |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Squamous Cell Skin Cancer | |

Do you wear Sunscreen? Yes No If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

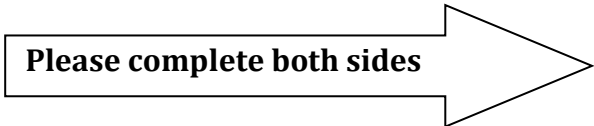
Do you have a family history of Melanoma? Yes No

If yes, which relative(s)? _____

List your current medications and the dose

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List allergies to medications _____



Tell us the reason for your visit today:

Please indicate if you have any of the following:

ALERTS:

- Allergy to Adhesive
- Allergy to lidocaine
- Allergy to topical antibiotics
- Artificial heart valve
- Artificial joint replacement
- Are you taking blood thinners
- Do you have a defibrillator
- Do you have a pacemaker
- Need antibiotics prior to a surgical procedure
- Pregnant or try to become pregnant?

REVIEW OF SYSTEMS:

- Problems with bleeding
- Problems with healing
- Problems with scarring
- Rash
- Immunosuppression
- Thyroid problems
- Fever or chills
- Joint aches
- Rapid heartbeat with epinephrine

Cigarette Smoking:

- Currently smokes
- Never smoked
- Former smoker

Alcohol Use:

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

Preferred **PHARMACY** _____

NAME OF PHARMACY

LOCATION

Please note:

If you do not designate a pharmacy, we will electronically submit your prescriptions to

CVS on 4th Street in Santa Rosa

Please PRINT YOUR NAME

DATE OF BIRTH

DATE

Please complete both sides

