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

__ Anxiety
__ Arthritis
__ Asthma
__ Atrial fibrillation
__ Transplantation
__ Breast Cancer
__ Coronary Artery Disease
__ Depression
__ Diabetes
__ Hepatitis
__ High Blood pressure
__ HIV/AIDS
__ Lymphoma
__ Radiation Treatment
__ NONE

PAST SURGERIES:

__ Heart Valve Replacement
__ Heart transplant
__ Joint Replacement
__ Kidney Transplant
__ Skin: Basal Cell Carcinoma
__ Skin: Melanoma
__ Skin: Squamous Cell Carcinoma
__ NONE

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

__ Acne
__ Actinic Keratoses
__ Asthma
__ Basal Cell Skin Cancer
__ Blistering Sunburns
__ Dry Skin
__ Eczema
__ Flaking or Itchy Scalp
__ Hay Fever/Allergies
__ Melanoma
__ Poison oak
__ Precancerous Moles
__ Psoriasis
__ Squamous Cell Skin Cancer
___ Other
_____
_____

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*_____

Please complete both sides

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