

MEDICAL HISTORY

Patient: _____

Date: _____

- When you are exposed to the sun, do you Tan Only Tan and Burn Burn
 - Any family history of skin cancer? NO YES, please explain
-

- Do you have any history of skin problems? NO YES, please explain
-

- Medication Allergies NO YES, please list
-

- List all medications you are currently taking:

1. _____
2. _____
3. _____

4. _____
5. _____
6. _____

* If needed, you may ask for a copy of your prescriptions to be made.

- Do you have now or have you ever had any of the conditions listed below: (please check yes or no)

	YES	NO		YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
			Type of Cancer	_____	

- List any major surgeries and/or hospitalizations:
-
-
-

- Are you pregnant? YES NO
- Do you smoke? YES NO

SIGNATURE _____

Patient or Legal Guardian

PHYSICIAN SIGNATURE _____ DATE _____