



Date _____ Chart # _____ Name _____

Referring Physician _____ DOB _____ Age _____ Sex _____

Please list **all** medications (over the counter and prescriptions) and **all** vitamins, herbal medicines, or dietary supplements that you take and specify what conditions they are for:

Are you **allergic** to any medications? NO YES If yes, list: _____

Please list **every** surgery you have had:

Please list **all** of your medical conditions (e.g. asthma, diabetes, high blood pressure, etc.):

Please list the names of **all** of your doctors (family doctor, gynecologist, pediatrician, cardiologist, etc.):

What is your occupation? _____

Have you ever had a history of, or do you currently have any of the following (please check yes or no below):

| YES | NO | EXPLAIN IF YES |
|-------|-------|---|
| _____ | _____ | Arthritis _____ |
| _____ | _____ | Diabetes &/or Thyroid condition _____ |
| _____ | _____ | Cancer (If yes, please specify type.) _____ |
| _____ | _____ | Blood clots / Lymphoma / Leukemia _____ |
| _____ | _____ | Skin cancer &/or Melanoma _____ |
| _____ | _____ | Excessive scarring or bleeding _____ |
| _____ | _____ | Artificial joints or heart valves _____ |
| _____ | _____ | Visual problems &/or eye disease _____ |
| _____ | _____ | Internal pacemaker or Defibrillator _____ |
| _____ | _____ | Liver problems / Hepatitis / Jaundice _____ |
| _____ | _____ | Kidney Disease _____ |
| _____ | _____ | Asthma &/or Hay fever _____ |
| _____ | _____ | Eczema _____ |
| _____ | _____ | Depression &/or Mental Illness _____ |
| _____ | _____ | Stroke _____ |
| _____ | _____ | HIV Disease / AIDS _____ |

| | YES | NO | |
|---|-------|-------|---|
| Do you use tanning beds? | _____ | _____ | If yes, number of times per week: _____ |
| Do you have a family history of asthma, hay fever, or eczema? | _____ | _____ | |
| Has anyone in your family had skin cancer? | _____ | _____ | If yes, explain: _____ |
| Do you use alcoholic beverages? | _____ | _____ | If yes, how many drinks per week? Please circle one: 1-2 3-6 7-14 15 or more |
| Do you smoke cigarettes or chew tobacco? | _____ | _____ | If yes, how much? _____ |
| Do you wear sunscreens? | _____ | _____ | |

DAK 014 11/10

SIGN HERE

| | | |
|-------------------------------------|-------------------------|--------------|
| SIGNATURE OF PERSON COMPLETING FORM | RELATIONSHIP TO PATIENT | MD SIGNATURE |
|-------------------------------------|-------------------------|--------------|