Pharmacy: Name:____
Street:_____________________________ Zip:________________

Primary Care Physician: ____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other ____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Knee Replacement (Right, Left, Both)
Hip Replacement (Right, Left, Both)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Spleen Removed
Testicles Removed (Right, Left, Both)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other ____

NAME:_____________________________ **Date of Birth:**_________**Today's Date:** ____________

MEDICATIONS: (Please enter all current medications) NONE

____

____

ALLERGIES: (Please enter all allergies) NONE

____

IMMUNIZATIONS:

Have you had your *influenza immunization*: Yes No

If No, why: Refused Allergy Other: _________________________

If 65 years or older, have you had your *pneumonia vaccine*: Yes No

If No, why: Refused Plan to receive

SOCIAL HISTORY:

If between ages of 12 and 20 years, indicate tobacco usage:

Never smoked Quit: Former Smoker

Smokes less than daily Smokes daily

SKIN DISEASE HISTORY: (please circle all that apply)

Skin Biopsy (If Yes, Location and Date: ____________________________)

Basal Cell Cancer (If Yes, Surgery ________________________)

Squamous Cell Carcinoma (If Yes: Surgery _________________)

Melanoma (If Yes: Surgery _____________)

Acne

Actinic Keratosis

Asthma

Blistering Sunburns

Dry Skin

Eczema

Flaking or Itchy Scalp

Hay Fever/Allergies

Poison Ivy

Precancerous Moles

Psoriasis

None

Other ____

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)? ____

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

Do you tan in a tanning salon? Yes No

Gender Identity: (please circle)

Male

Female

Transgender Male (TGM)

Transgender Female (TGF)

Genderqueer

Other

Choose not to disclose

Unspecified