

Pharmacy: Name: _____
Street: _____ Zip: _____

Primary Care Physician: _____

Past Medical History: (please circle all that apply)

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

Past Surgical History: (please circle all that apply)

Appendix Removed	Joint Replacement within last 2 years
Bladder Removed	Kidney Biopsy
Mastectomy (Right, Left, Bilateral)	Kidney Removed (Right, Left)
Lumpectomy (Right, Left, Bilateral)	Kidney Stone Removal
Breast Biopsy (Right, Left, Bilateral)	Kidney Transplant
Breast Reduction	Ovaries Removed: Endometriosis
Breast Implants	Ovaries Removed: Cyst
Colectomy: Colon Cancer Resection	Ovaries Removed: Ovarian Cancer
Colectomy: Diverticulitis	Prostate Removed: Prostate Cancer
Colectomy: IBD	Prostate Biopsy
Gallbladder Removed	TURP
Coronary Artery Bypass	Spleen Removed
PTCA	Testicles Removed (Right, Left, Both)
Mechanical Valve Replacement	Hysterectomy: Fibroids
Biological Valve Replacement	Hysterectomy: Uterine Cancer
Heart Transplant	None
Knee Replacement (Right, Left, Both)	
Hip Replacement (Right, Left, Both)	
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	Flaking or Itchy Scalp
Actinic Keratosis	Hay Fever/Allergies
Asthma	Poison Ivy
Blistering Sunburns	Precancerous Moles
Dry Skin	Psoriasis
Eczema	None
Other _____	

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____
Do you wear Sunscreen? Yes No If yes, what SPF? _____
Do you tan in a tanning salon? Yes No