PATIENT INFORMATION Date____________

Patient Last Name ___________________First _________________MI_______

Pharmacy:____

Family Doctor _____________________ Referred by ______________________

Occupation ________________________

If your health is affected by any condition or disease, please circle or write in below:

ARTIFICIAL JOINT	DIABETES	HIV/ AIDS
ARTHRITIS	HEART ATTACK	LUNG PROBLEMS
ASTHMA	HEART SURGERY	KIDNEY DISEASE
BLOOD DISORDER	HEART PACEMAKER	STOMACH ULCERS
____________ CANCER	HEART VALVE PROBLEMS	_________TRANSPLANT
CIRCULATION PROBLEMS	HEPATITIS	TUBERCULOSIS
COLON PROBLEMS	HIGH BLOOD PRESSURE	

Other health problems: ____
____

Surgeries: ____
____

Drug Allergies: ____

Current Medications: ____
____
____

Do you take aspirin daily? Yes______ No______ Are you on blood thinner? Yes______ No______

Do you smoke cigarettes? No______ Yes-Packs per day______ Quit on ________

About how many drinks of alcohol do you have per week? ________

Do you have any close relatives with history of skin cancer or other skin disease? _______________

Family Members who have been seen in our office _______________________________________

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Updated ____