MEDICAL HISTORY

Patient Name:_____ **Date of Birth :** _____

Have you ever had skin cancer? Y / N If yes, was it basal cell, squamous cell, or melanoma? _____

Where was it located? How and when was it treated? _____

Do you have a family history of basal cell, squamous cell, or melanoma? _____

Do you have dry skin, eczema, or psoriasis? _____

Does a family member have dry skin, eczema, or psoriasis? _____

Do you smoke? How many cigarettes a day do you smoke?_____

Did you have a drink containing alcohol in the past year? ❑ **Yes** ❑ **No**

If 'Yes': How often did you have six or more drinks on ONE occasion in the past year?

❑ Never ❑ Less than monthly ❑ Monthly ❑ Weekly ❑ Daily or almost daily

If 'Yes': How many drinks did you have on a typical day when you were drinking in the past year?

❑ 1 or 2 ❑ 3 or 4 ❑ 5 or 6 ❑ 7 to 9 ❑ 10 or more

If 'Yes': How often did you have a drink containing alcohol in the past year?

❑ **Never** ❑ **Monthly or less** ❑ **2 to 4 times a month** ❑ **2 to 3 times per week** ❑ **4 or more times a week**

Do you exercise? _____ **Do you wear sunscreen regularly?** _____

Have you ever used a tanning bed?_____

Are you interested in cosmetic procedures? _____

Do you have any body piercing or tattoos? _____

Do you have a history of drug use? _____

Are you married?_____**What is your occupation?**_____

Have you ever received a pneumonia vaccine? If yes, date_____

Have you had the flu shot within the last year? If yes, date_____

Do you have any chronic medical or skin conditions (please list)? _____

_____

Please list all current medications (including creams) _____

_____

Please list all drug or food allergies _____