

PATIENT INFORMATION					
First Name		Middle Initial	Last Name		Date
Date of Birth		Sex: M <input type="checkbox"/> F <input type="checkbox"/>		Age	
Please check the box next to the location where we may leave a message with private information such as a biopsy result:					
Phone: <input type="checkbox"/> Home: _____ <input type="checkbox"/> Work: _____ <input type="checkbox"/> Cell: _____					
<input type="checkbox"/> I have no specific requests for confidential communication.					
Pharmacy Name		Pharmacy Phone		Location	
Who is your primary care doctor?				Phone number	
What is the reason for your visit?					
Do you have a history of any skin problems?					
List, or provide a list, of your current medications (prescription and non-prescription)		1.		5.	
		2.		6.	
		3.		7.	
		4.		8.	
List all Allergies					
List all known medical conditions and past surgeries					
Do you have a history of skin cancer? If yes, what type? Location and date		<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> Basal Cell <input type="checkbox"/> Squamous Cell <input type="checkbox"/> Melanoma <input type="checkbox"/> Other	
Family history of skin cancer?		<input type="checkbox"/> No <input type="checkbox"/> Yes		Type?	
How often do you apply sunscreen?				What SPF?	
Have you had any recent cosmetic or elective treatments to your skin?		<input type="checkbox"/> No <input type="checkbox"/> Yes		What type?	
Do you take blood thinners daily?		<input type="checkbox"/> No <input type="checkbox"/> Yes		Please circle: Aspirin, Coumadin/ warfarin, Plavix, Lovenox, Ibuprofen, Aleve, Other _____	
Do you have any implantable devices (pacemaker, artificial joint, defibrillator)?		<input type="checkbox"/> No <input type="checkbox"/> Yes		What type?	
Have you ever had any reaction to local anesthesia such as lidocaine or novacaine?		<input type="checkbox"/> No <input type="checkbox"/> Yes		What type?	
Do you have HIV/Aids?		<input type="checkbox"/> No	<input type="checkbox"/> Yes	Are you pregnant?	
				<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have Hepatitis C?		<input type="checkbox"/> No	<input type="checkbox"/> Yes	Are you trying to become pregnant?	
				<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you drink alcohol? How much?		<input type="checkbox"/> No	<input type="checkbox"/> Yes	Are you breastfeeding?	
				<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you smoke?		<input type="checkbox"/> No	<input type="checkbox"/> Yes	Do you use illegal drugs?	
				<input type="checkbox"/> No	<input type="checkbox"/> Yes