PATIENT INFORMATION

Date _____ Email address: _____

By whom were you referred? Name _____ PREFERRED LANGUAGE: _____

NAME (Last) _____ (First) _____ BIRTHDATE: _____ AGE ___

ADDRESS: _____ BLDG. # _____ APT. # _____

CITY STATE ZIP CODE _____

CELL PHONE #: _____ OTHER PHONE #: _____

PHARMACY NAME AND LOCATION where we will send your prescriptions electronically:

_____

EMPLOYER _____ SPORTS/ WORK IN THE SUN? _____

BUSINESS PHONE _____ ADDRESS: _____

MARITAL STATUS: ( ) SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOW(ER)

SPOUSE'S NAME _____ CHILDREN (AGES & SEX) _____

HEALTH HISTORY: PAST OR PRESENT **ILLNESSES OR OPERATIONS** AND APPROX.DATES

CANCER HX? TYPE & RX DATES: _____ _____

TRANSPLANT? DATE: KIDNEY _____ LIVER _____ OTHER _____

EYES, EARS, NOSE, THROAT, MOUTH _____ STUFFY NOSE___ FEVER BLISTERS _____

HEART: _____ **PACEMAKER?** ____ I BL PRESSURE: ___ **ANTICOAGULANTS?** _____

LUNGS:ASTHMA ___ COPD __ OTHER _____ DAILY, OCCASIONAL, FORMER, NEVER SMOKER.

STOMACH/BOWEL/KIDNEYS: _____ ORTHOPEDIC PROSTHESIS? _____

ARTHRITIS:___ DIABETES: __ THYROID: ____ PROSTATE:_____ HEADACHE/SEIZURES? _____

LIVER: HEPATITIS B or C _____ IMMUNE SYSTEM: HIV+ _____ OTHER? _____

DERMATOLOGY HISTORY:

CIRCLE IF PERSONAL OR FAMILY HISTORY OF: **MALIGNANT MELANOMA, SKIN CANCER.** SKIN CONDITIONS: ECZEMA, PSORIASIS, DANDRUFF, ACNE, OTHER _____

TANNING BED USE? Y or N FOR WOMEN: PREGNANT? Y or N PLANNING PREGNANCY? Y or N

MEDICATION HISTORY: LIST **ALLERGIES** (Drugs, Food, Topical, etc) _____

MEDICATION presently using (Including birth control, vitamins, laxatives, health food supplements)

_____

_____

_____

ARE YOU TAKING ASPIRIN? BLOOD THINNERS? _____

HEART VALVE OR ORTHOPEDIC PROSTHESIS REQUIRING PRE-MEDICATION? _____

PRIMARY PHYSICIAN: NAME: _____ PHONE: _____

TURN OVER PAGE, READ, AND SIGN AT THE BOTTOM