

Medical History Form

Name: _____

Date: _____

Preferred Pharmacy

Name: _____

Primary Care Physician _____

Phone Number: _____

Referring Physician _____

City or Zip Code: _____

Do we have permission to import medication from your pharmacy Yes No

Past Medical History

Select any of the following medical conditions you currently have:

- | | | |
|---|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Arthritis/Joint problems | <input type="checkbox"/> GERD | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> (AF) Irregular Heartbeat | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> BPH (Enlarged prostate) | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Other |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> High cholesterol | _____ |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Overactive Thyroid (Hyper) | _____ |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Low Thyroid (Hypo) | _____ |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Leukemia | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lung Cancer | |
| <input type="checkbox"/> Diabetes | | |

Past Surgical History

Have you had any surgeries on the following organs (Please circle appropriate location or condition)

- | | |
|---|--|
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Colon: Colostomy |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Gallbladder |
| <input type="checkbox"/> Breast Biopsy | <input type="checkbox"/> Heart Valve Replacement (Tissue or Mechanical) |
| <input type="checkbox"/> Breast: Lumpectomy (Both, Left or Right) | <input type="checkbox"/> Heart Bypass |
| <input type="checkbox"/> Breast: Mastectomy (Both, Left or Right) | <input type="checkbox"/> Heart Transplant |
| <input type="checkbox"/> Colon: Cancer Resection | <input type="checkbox"/> PTCA (Angioplasty or Stent) |
| <input type="checkbox"/> Colon: Diverticulitis | <input type="checkbox"/> Joint Replacement – Knee: Right, Left or Both Sides |
| <input type="checkbox"/> Colon: Inflammatory Bowel Disease | <input type="checkbox"/> Joint Replacement – Hip: Right, Left or Both Sides |

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- Kidney: Biopsy, Stone Removal, Transplant, Removal
- Liver: Partial removal, transplant or shunt
- Ovaries removal: Endometriosis, Cancer or Cysts
- Ovaries: Tubal Ligation
- Pancreas: Partial removal
- Prostate: Biopsy, Cancer or TURP
- Rectum: APR- Resection of the Rectum

- Skin: Basal Cell, Squamous Cell, Melanoma
 - Spleen (Removal)
 - Testicles (Removal)
 - Uterus: (Removal) Fibroids, Uterine or Cervical Cancer
 - Other
- _____
- _____
- _____

Females Only:

Are you currently pregnant? Yes No
 LMP: _____

Skin Disease History

Have you had any of the following?

- Acne
 - Actinic Keratoses
 - Basal Cell Skin Cancer
 - Blistering Sunburns
 - Eczema
 - Flaking or Itchy Scalp
 - Hay Fever / Allergies
 - Melanoma Skin Cancer
 - Poison Ivy
 - Precancerous Moles
 - Psoriasis
 - Squamous Cell Skin Cancer
 - Other
- _____
- NONE

Do you wear Sunscreen?

Yes No
 If yes, what SPF? _____

Do you tan in a tanning salon?

Yes No

Family History

Do you have a family history of Melanoma? Yes No
 If yes, which family member(s)?

Medical History Form

Medications

List all current medications: (Please include dosage and strength if known)

Allergies

List all allergies and reactions if known:

Social History

Smoking Status (please choose one):

- Current every day smoker
- Current someday smoker
- Former smoker
- Never smoker
- Unknown if ever smoked

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- None
- 1 or less per day
- 1-2 per day
- 3 or more per day