Patient's Name: ______________________________ **DOB:** ______________

MEDICAL & SOCIAL HISTORY

Skin History: (please check all that apply)

☐ Acne ☐ Actinic Keratoses ☐ Basal Cell Skin Cancer

☐ Blistering Sunburns ☐ Dry Skin ☐ Eczema

☐ Flaking or Itchy Scalp ☐ Hay Fever/Allergies ☐ Melanoma

☐ Precancerous Moles ☐ Psoriasis ☐ Squamous Cell Skin Cancer

☐ None Other: ____

Do you have a family history of Melanoma? ☐ Yes ☐ No

If yes, which relative(s)?

☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Aunt ☐ Uncle

☐ Grandmother (maternal) ☐ Grandmother (paternal) ☐ Grandfather (maternal)

☐ Grandfather (paternal) Other: _____________________________________

Any other family history? ____

Do you wear sunscreen? ☐ Yes ☐ No If yes, what SPF? __________

Do you tan in a tanning salon? ☐ Yes ☐ No

Medications: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, etc.

☐ TAKE NO MEDICATIONS

Medication Dose (e.g. mg/pill) How many times per day?

____

____

____

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Preferred Pharmacy: ________________________________ Phone#: ________________________

Pharmacy Location: ____

Allergies or Intolerance to medications (include type of reaction): ☐ NONE

____

____

Social History:

Alcohol Use: Do you drink alcohol? ☐ No ☐ Yes If Yes, #of drinks / week: ____

Sexual Activity: Sexually active? ☐ No ☐ Yes

Tobacco Use: Smoke cigarettes: ☐ Never ☐ No ☐ Yes

Current smoker: Packs / day: _____ #of years: _____

Quit date: ___________ How many years did you smoke? ______

Drug Use: ☐ Never ☐ No ☐ Yes

Preferred language: ____

Gender: ☐ Male ☐ Female

Race: ☐ Black ☐ Caucasian ☐ Asian ☐ American Indian/Alaskan Native

☐ Native Hawaiian/Pacific Islander Other: ______________________________

Ethnicity: ☐ Non-Hispanic or Non-Latino ☐ Hispanic or Latino