

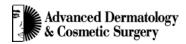
## **Medical History Form**

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:				
Anxiety Arthritis/Joint problems Asthma (AF) Irregular Heartbeat Bone Marrow Transplant BPH (Enlarged prostate) Breast Cancer Colon Cancer COPD Coronary Artery Disease Depression Diabetes	End Stage Renal Disease  GERD  Hearing Loss  Hepatitis A/B/C  High blood pressure  HIV/AIDS  High cholesterol  Overactive Thyroid (Hyper)  Low Thyroid (Hypo)  Leukemia  Lung Cancer		Lymphoma Prostate Cancer Radiation Treatment Seizures Stroke Other	
Past Surgical History				
Have you had any surgeries on the following organs (Please circle appropriate location or condition)				
Appendix		Colon: Col	ostomy	
Bladder		Gallbladder		
Breast Biopsy		Heart Valve Replacement (Tissue or Mechanical)		
Breast: Lumpectomy (Both, Left or Right)		Heart Bypass		
Breast: Mastectomy (Both, Left or Right)		Heart Transplant		
Colon: Cancer Resection		PTCA (Angioplasty or Stent)		
Colon: Diverticulitis		Joint Replacement – Knee: Right, Left or Both Sides		
Colon: Inflammatory Bowel Disease		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	Skin: Basal Cell, Squamous Cell, Melanoma Spleen (Removal) Testicles (Removal) Uterus: (Removal) Fibroids, Uterine or Cervical Cancer Other
Prostate: Biopsy, Cancer or TURP Rectum: APR- Resection of the Rectum	
Females Only:  Are you currently pregnant? Yes No LMP:  Skin Disease History	
Have you had any of the following?	Do you wear Sunscreen?
Acne	Yes No
Actinic Keratoses	If yes, what SPF?
Basal Cell Skin Cancer	Do you tan in a tanning salon?
Blistering Sunburns	Yes No
Eczema	
Flaking or Itchy Scalp	
Hay Fever / Allergies	
Melanoma Skin Cancer	
Poison Ivy	
Precancerous Moles	
Psoriasis	
Squamous Cell Skin Cancer	
Other	
NONE	
Family History	
Do you have a family history of Melanoma?  If yes, which family member(s)?	Yes No



## **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):	Alcohol Intake (please choose one):			
Current every day smoker	None			
Current someday smoker	1 or less per day			
Former smoker	1-2 per day			
Never smoker	3 or more per day			
Unknown if ever smoked				
Number of Packs Per Day:				
Total Years Smoking:				