

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ DATE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ CITY/STATE BORN IN: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ DO YOU SMOKE? \_\_\_\_\_

DO YOU REQUIRE ASSISTANCE WITH DRESSING OR BATHING? \_\_\_\_\_

DO YOU LIVE ALONE? \_\_\_\_\_

LIFETIME SUN EXPOSURE: HIGH MODERATE LOW (circle one)

DO YOU USE A TANNING BED? \_\_\_\_\_ DO YOU USE SUNSCREEN? \_\_\_\_\_

DO YOU HAVE A HISTORY OF BLISTERING SUNBURNS? \_\_\_\_\_

DO YOU HAVE OR HAVE YOU EVER HAD (circle yes or no):

High blood pressure	Y	N	Hepatitis	Y	N
Ulcer	Y	N	Blood Transfusion	Y	N
Heart attack/angina	Y	N	Artificial heart valve or joint	Y	N
Irregular heart beat	Y	N	Abnormal healing or scarring	Y	N
Seizure disorder	Y	N	Surgery	Y	N

Explain:

DO YOU OR ANY OF YOUR BLOOD RELATIVES HAVE A HISTORY OF:

Diabetes	me	relative	Melanoma	me	relative
Lupus	me	relative	Other skin cancer	me	relative
Eczema	me	relative	Psoriasis	me	relative
Asthma	me	relative	Bleeding disorder	me	relative
Hayfever	me	relative	Non-skin cancer	me	relative

Explain:

DO YOU HAVE ANY CURRENT HEALTH PROBLEMS NOT ADDRESSED ABOVE? (circle if so)

Blood/circulatory system	Kidneys	Anxiety/depression	Joints
Lymph nodes	Nervous system	Digestive System	Liver
Fevers	Allergies	Persistent headaches	Lungs
Ears/nose/mouth/throat	Eyes	Genitals	Thyroid gland
Bowels/bladder	Muscles/bones		

Explain:

PLEASE LIST ALL CURRENT MEDICATIONS (including over the counter, vitamins, herbs, supplements)

ARE YOU ALLERGIC TO ANY MEDICATIONS, TOPICAL PRODUCTS OR ADHESIVES?

ARE YOU PREGNANT OR NURSING?

ANY RECENT TRAVEL?