Skin Disease History:

Acne	Precancerous Moles	Dry Skin
Asthma	Melanoma	Poison Ivy
Eczema	Basal Cell Carcinoma	Flaking/Itchy Scalp
Psoriasis	Squamous Cell Carcinoma	Hay Fever/Allergies
Actinic Keratosis (precancerous sun spots)		Blistering Sunburns

Do you wear sunscreen: (please circle) ☐ Yes ☐ No Tanning Salon History: ☐ Yes ☐ No

If yes to sunscreen, what is the SPF: _____

How often applied during the day: _____

Family History:

Do you have a family history of melanoma: (please circle) ☐ Yes ☐ No

Which relative? _____

Medications: (Please list all medications and supplements with their dosage strength & frequency)

_____

_____

_____

_____

_____

_____

Medication Allergies: **None (Please circle if none)**

_____

_____

_____

_____

Social History:

Smoking Status (please check one)

☐ Never smoked ☐ Former smoked ☐ Current Someday Smoker ☐ Current Everyday Smoker

Alcohol Status (please check one)

☐ None ☐ Less than 1 drink ☐ 1-2 drinks per day ☐ 3 or more drinks per day

Did you receive your flu vaccine this year? ☐ Yes ☐ No

Have you received the pneumonia vaccine? ☐ Yes ☐ No