Health History Form

Name: ______________________________ **Date of Birth:** ____________________

Past Medical History

YES/NO Cancer (other than skin cancer)
YES/NO Cold Sores
YES/NO Depression or anxiety
YES/NO Diabetes
YES/NO Gastrointestinal Illness
YES/NO Hepatitis
YES/NO High Blood Pressure
YES/NO High Cholesterol
YES/NO HIV
YES/NO Pacemaker/Defibrillator
YES/NO Thyroid Disorder
YES/NO Tuberculosis

Skin History

YES/NO Personal history of skin cancer
YES/NO Personal history of melanoma
YES/NO Family history of skin cancer
YES/NO Have you ever used a tanning bed?
YES/NO Do you wear sunscreen consistently?

Primary Care Provider

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Current Height & Weight: ______________________

Allergies and Medications (including supplements & over-the-counter)

Current medications: ____

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Medication/food allergies: ____

Do you have a reaction to any of the following? Circle all that apply.

None Rubber/latex Egg (allergy) Milk (allergy) Local anesthetics (e.g., lidocaine) Epinephrine (allergy or sensitivity)

Topical antibiotics (e.g., Neosporin) Surgical tape/bandages

Preferred Pharmacy: ______________________________

Family History ☐ **Adopted or Unknown History**

YES/NO Arthritis
YES/NO Autoimmune Disorders
YES/NO Cancer (other than skin)
YES/NO Diabetes
YES/NO Hay fever, asthma, allergies

Surgical History

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Social History

Tobacco status: (including vaping/e-cigarettes)	Never tobacco user	Former tobacco user	Current tobacco user
Alcohol use:	Never drink alcohol	Occasionally drink alcohol	Drink alcohol daily
Caffeine use:	Never drink caffeine	Less than 3 servings/day	More than 3 servings/day

For females:

YES/NO Do you take or use any forms of birth control?
If so, what kind? ______________________________
YES/NO Regular menstrual cycles

YES/NO Pregnant or attempting pregnancy
YES/NO Breastfeeding