

Name: _____

Please list all current MEDICATIONS and DOSAGE (including non-prescription):

Allergies: _____

Surgeries and/or hospitalizations:

Never hospitalized

Year	Operation or Illness	Year	Operation or Illness

Family History:

Do you have a family history of :

	YES	NO	Relationship (whom?)
Malignant Melanoma?	YES	NO	_____
Other Skin Cancer?	YES	NO	_____
Eczema?	YES	NO	_____
Psoriasis?	YES	NO	_____
Lupus or other connective tissue disease?	YES	NO	_____

Social History:

Do you smoke? YES NO

If yes, how many packs of cigarettes/day? _____

How many alcoholic beverages (glasses of wine, beer, mixed drinks) on average do you have per week? _____

Do you or have you used recreational drugs? YES NO

What is your occupation? _____

Are you currently pregnant or breast feeding? YES NO

Patient Signature: _____

Physician Initials: _____

Date: _____