



4321 University Parkway □ Suite 103 □ Evans, GA 30809
University Professional Center 2 □ Evans Campus
706 650-SKIN (7546)

Patient Name: _____ **Date:** _____

Primary Care Doctor: _____ **Pref. Pharmacy:** _____

Medical history: *Check all that apply and explain if needed*

- | | |
|---|--|
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Kidney Disease _____ | <input type="checkbox"/> High Cholesterol _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Lung disease _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Liver Disease _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> HIV / AIDS _____ |

Skin history: *Check all that apply and explain if needed.*

- Skin Cancer _____
- Melanoma _____
- Lupus _____
- Psoriasis _____
- Eczema _____

Family History: *Check all that apply and explain if needed.*

- Skin Cancer _____
- Melanoma _____
- Lupus _____
- Psoriasis _____
- Eczema _____

Social History:

Lifetime sun exposure: Little Moderate A lot
Do you wear sunscreen regularly? No Yes _____
Do you drink alcohol? No Yes How much? _____
Do you smoke? No Yes How much? _____
Occupation _____

List the names (dose not needed) of all medications you are taking:

List any drug or food allergies:
