



<b>3</b>	<b>SKIN CARE PRODUCTS YOU CURRENTLY USE – Please List</b>	
	Cleanser	
	Antioxidant	
	Sunscreen	
	Scrubs/Peels	
	Other	

<b>4</b>	<b>SERIOUS Hospitalizations and Surgeries – Medical and Dental</b>	<b>YES</b>	<b>NO</b>
	Have you had any SERIOUS hospitalizations or surgeries?		
	<b>If YES, Please List Them with Dates</b>		

<b>5</b>	<b>SKIN HISTORY</b>	<b>YES</b>	<b>If YES, Please Describe</b>
	Have you ever had melanoma? (Please Describe)		
	Have you ever had another type of skin cancer? (Please Describe)		
	Has anyone in your family ever had skin cancer? (Please Describe)		
	Have you ever had atypical nevi or moles?		
	Do you have any changing moles or spots?		
	Have you ever had any lesions that haven't healed?		
	Have you used Isotretinoin (Accutane) in the last year?		
	Do you have a history of any specific skin diseases or conditions?		
	Do you tan in a tanning bed or sunbathe?		
Date of last Total Body Skin Exam?			
Do you have a history of acne, eczema, or psoriasis?			

<b>6</b>	<b>Medications</b>	<b>YES</b>	<b>NO</b>
	Are You Currently Taking Any Medications Including Aspirin, Pain Relievers, Herbals, Vitamins or Supplements?		
	<b>If YES, Please List All Medications That You are Taking</b>		
	Medications	Dose	
	1		
	2		
	3		
4			
5			

<b>7</b>	<b>ALLERGIES</b>	<b>YES</b>	<b>NO</b>
	Do you currently have any allergies?		
	<b>If YES, Please List and Describe Reactions (i.e. seasonal, latex, anesthesia, medications, etc.)</b>		

<b>8</b>	<b>Tobacco Use</b>	<b>YES</b>	<b>NO</b>
	Do you smoke or have you ever smoked?		
	Do you or have you ever used chewing tobacco or snuff?		

**Information Verification**

By signing this form, I confirm that all information provided above is accurate and complete to the best of my knowledge

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date