Westchester Health

Name: ____Today's Date: ___/____/____

DOB: ________/_________/_________ Age:__________ Male:________Female:_____________

Reason for Today's visit:____

Medications currently being taken (Include all medications, including OTC):

1) ____________________________2)_________________________3)________________

4) ____________________________5)__________________________

List any Allergies:____

Do you have now, or have you ever had diseases or conditions of: (please check Yes or No)

	YES	NO		YES	NO
Diabetes	( )	( )	High Blood Pressure	( )	( )
Heart Problems	( )	( )	Pacemaker	( )	( )
Bleeding Problems	( )	( )	Other: __________________________________		

SKIN:	YES	NO
Person History of skin cancer	( )	( ) if yes, explain____________
Family Hx of skin cancer/melanoma	( )	( ) if yes, who:_____________
Do you have hx of any specific skin diseases?	( )	( )

If yes, please list: ____

Do you have any new growths or changes in an existing one? __________________________

Do you use sunscreen? ___________________________

List surgical procedures/hospitalization you have in the last 6 months:

____

Social History:	YES	NO
Do you drink alcohol?	( )	( )
Do you smoke	( )	( )
Have you had or have you been exposed to HIV (AIDS)	( )	( )
Have you had or have you been exposed to Hepatitis	( )	( )

What is you occupation? ____

What are your hobbies? ____

For Women Only:	YES	NO
Are you pregnant or planning to get pregnant?	( )	( )
Are you breastfeeding?	( )	( )

Completed by:_____________________________Patient signature:___________________________