

Rebecca M. Jones, MD., LLC

Name: _____ Date of Birth: _____

Primary Physician: _____

List any diseases or medical conditions? _____

PLEASE LIST:

All medications that you take (including ALL herbal and non-prescription):

Surgical Procedures you have had: _____

ALLERGIES TO MEDICATION: _____

Other Allergies: (i.e., mold, beestings): _____

Do you or any immediate family members have a history of Melanoma? _____ Y _____ N

If yes, whom? _____

Personal or family history of Basal or Squamous Cell skin cancer? _____ Y _____ N

If yes, whom? _____

Have you experienced 5 or more blistering sunburns? _____ Y _____ N

Did you spend the 1st 20 years of life in a tropical environment? _____ Y _____ N

Other skin diseases? (Please list): _____

Have you ever used a tanning bed? _____ Y _____ N

Please check all that apply to you:

- _____ Psoriasis/or family history of
- _____ Eczema/or family history of
- _____ Asthma
- _____ Cancer (type): _____
- _____ Heart disease
- _____ Pacemaker
- _____ HIV / AIDS
- _____ Hepatitis

- _____ Diabetes
- _____ Thyroid Disease
- _____ Artificial joint/Heart Valve
- _____ Stomach/bowel problems
- _____ Alcohol
- _____ Convulsions/Epilepsy/Seizures
- _____ Fainting
- _____ Glaucoma

Patient (parent/guardian) signature: _____ Date: _____