

HEALTH QUESTIONNAIRE

NAME: _____

DATE: _____

NAME OF PHARMACY YOU USE: _____

CIRCLE Y (YES) OR N (NO) FOR ALL QUESTIONS

I) HAVE YOU EVER HAD?:

DIABETES:	Y OR N	HEART VALVE REPLACED:	Y OR N	KIDNEY DISEASE:	Y OR N
PACEMAKER:	Y OR N	TUBERCULOSIS OR EXPOSURE:	Y OR N	LIVER DISEASE OR HEPATITIS:	Y OR N
AIDS OR HIV:	Y OR N	LAST MENSTRUAL CYCLE:	_____	BLISTERING SUNBURNS:	Y OR N
SKIN CANCER:	Y OR N	CURRENTLY PREGNANT:	Y OR N	BLOOD TRANSFUSION:	Y OR N
ARTIFICIAL JOINTS:	Y OR N	CURRENTLY BREASTFEEDING:	Y OR N	OTHER CANCER:	Y OR N

OTHER: _____

II) HAS ANYONE IN YOUR FAMILY HAD?:

MELANOMA:	Y OR N	SCARRING ACNE:	Y OR N	ROSACEA:	Y OR N
PSORIASIS:	Y OR N	ECZEMA:	Y OR N		

III) DO YOU USE?:

CIGARETTES:	Y OR N	SMOKELESS TOBACCO:	Y OR N	ALCOHOL :	Y OR N
TANNING BEDS:	Y OR N	SUNSCREEN:	Y OR N		

IV) MEDICINE ALLERGIES: _____

V) MEDICATIONS: _____