

MEDICAL HISTORY FORM

Today's Date: ____ / ____ / ____

PATIENT NAME: _____
LAST NAME FIRST NAME

M / F Date of Birth: ____ / ____ / ____

Preferred *First Name* (if applicable): _____

REASON FOR VISIT: (Mark on the diagram the location of your skin condition)

How long? _____ Past treatments, if any? _____

LIST ALL CURRENT MEDICATIONS:

(Include prescriptions and over-the-counter):

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

PHARMACY INFORMATION:

Preferred Pharmacy Name: _____

ADDRESS _____ PHONE _____

ALLERGIES:

Are you ALLERGIC to any medications? **YES** **NO**

If yes, list below which medication(s) and what reaction(s):

Have you ever had a reaction to local anesthesia? **YES** **NO**

If yes, explain:

Are you allergic to latex? **YES** **NO**

Do you develop skin rashes in reaction to the following?: (circle below)

Bandages Neosporin Polysporin Other _____

SKIN: Do you have a history of any of the following?

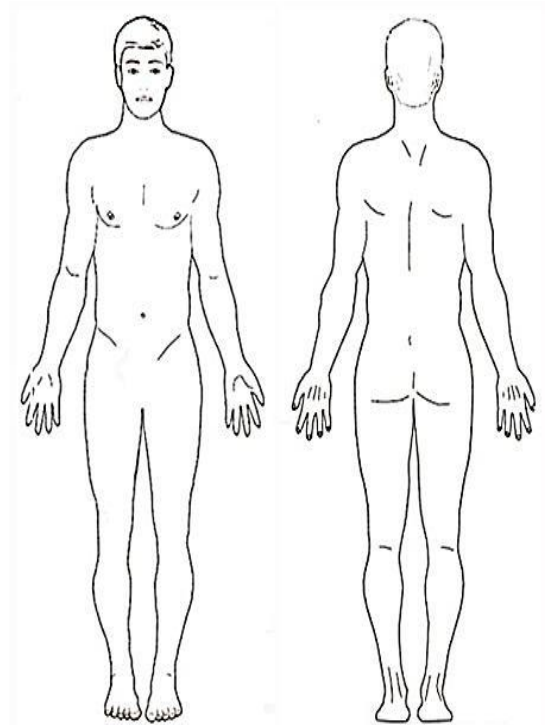
- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Actinic Keratosis (pre-cancerous lesions) | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Squamous Cell Carcinoma | |

If yes, please provide details _____

Do you have a history of any skin diseases? **YES** **NO** If yes, please explain: _____

Have you had abnormal moles? **YES** **NO** If yes, any removed? **YES** **NO** If yes, location? _____

Do you develop keloid scars in response to surgery? **YES** **NO**



CURRENT SKIN CARE PRODUCTS:

Do you wear sunscreen on a regular basis? YES NO

Do you wish to discuss your skin care today? YES NO

PATIENT NAME: _____
LAST NAME FIRST NAME

MEDICAL/SURGICAL HISTORY - Please check if any of the following conditions apply to you:

CARDIOVASCULAR:

- None
- Hypertension (high blood pressure)
- Myocardial Infarction (heart attack)
If so, when _____
- Heart valve problems
If so, type: _____
- Pacemaker / Defibrillator
- Other: _____

GASTROINTESTINAL:

- None
- Gastroesophageal Reflux Disease (GERD)
- Stomach Ulcer
- Colitis (ulcerative/chronic)
- Liver Disease
- Other: _____

GENITOURINARY:

- None
- Kidney Disease
- Dialysis
- Other: _____

HEMATOLOGIC:

- None
- Anemia
- Bleeding Disorders
If so, type: _____
- Other: _____

IMMUNOLOGIC:

- None
- Seasonal allergies
- Lupus

INFECTIOUS DISEASE:

- None
- Hepatitis If so, type: **A , B or C**
- HIV / AIDS
- Herpes
- STDs / VD
- Tuberculosis (TB)
- Valley Fever
- Other: _____

METABOLIC / ENDOCRINE:

- None
- Diabetes
If so, type: _____
- Thyroid Disorder

MUSCULOSKELETAL:

- None
- Muscular Dystrophy
- Osteoarthritis
- Fibromyalgia
- Artificial Joint
If so, type: _____

NEOPLASTIC

- None
- Cancer (other than skin)
If so, type: _____
- Lymphoma
If so, type? _____
- Chemotherapy / Radiation /Surgery
If so, when: _____

NEUROLOGIC:

- None
- Dementia
- Multiple Sclerosis
- Seizure Disorder
- Peripheral Neuropathy
- Cerebrovascular Accident (stroke)

PSYCHIATRIC:

- None
- Depression
- Anxiety

PULMONARY:

- None
- Asthma
- Bronchitis
- Emphysema
- COPD

REPRODUCTIVE HEALTH:

- Irregular Menstrual Cycle
 - Polycystic Ovary Syndrome
 - Hysterectomy
- Are you pregnant or planning on becoming pregnant? **Y N**

**HORMONES FOR GENDER / SEX
TRANSITIONING**

- Are you currently taking hormones for gender / sex transitioning purposes? **Y N**
If YES: How long have you been taking them?

Do you require antibiotics before dental procedures? **YES NO**

OTHER SURGERIES If yes, please explain type of surgery: _____

FAMILY HISTORY:

Family history of Skin Cancer? **YES NO** If yes, type: _____

SOCIAL HISTORY:

Alcohol: amount _____ per day/week

Tobacco Use (circle): **Current**, Type: _____ **Former**, how long ago did you quit? _____ **Never**

Occupation/Former Occupation: _____

Patient Signature

Parent / Guardian Signature

Provider Signature / MA Initial

Date

