Medical History Form

Name ____ Date of Birth ____/_____/_______

How did you hear about our practice? ________________ Primary care doctor ______________________________

What is the reason for your visit today? ____

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Past Medical History (check all that apply)
Do you have a history of the following?

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autoimmune disease
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Bleeding disorder
- ☐ Colon Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Kidney disease
- ☐ GERD or reflux
- ☐ Hearing loss
- ☐ Hepatitis
- ☐ High Blood Pressure or Hypertension
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Thyroid disease
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Radiation treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other Cancer ______________________________
- ☐ HSV/cold sores

Other:

____

Skin Disease History (check all that apply)
Do you have a History of the following?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry skin
- ☐ Eczema
- ☐ Flaking or itchy scalp
- ☐ Hay fever or allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer

Other____

Family History

Do you have a family history of Melanoma? ☐ No ☐ Yes Whom: ______________________________

Do you have a family history of other skin cancer? ☐ No ☐ Yes Whom and type: ____________________

Other Family History ____

Please answer below only if you are a woman

Are you breastfeeding? ☐ No ☐ Yes

Are you on birth control? ☐ No ☐ Yes What Type: ________________________________

Social History Occupation ______________________

Do you wear sunscreen? ☐ No ☐ Yes How often: ______________________

Do you go to tanning bed? ☐ No ☐ Yes How often: ______________________

Do you use tobacco? ☐ No ☐ Yes Type and amount: ______________________

Alcohol use ☐ none ☐ socially ☐ moderate ☐ heavy

Medications

Name	Dose and frequency	Purpose

Please attach a separate list if needed

Medication or Other Medical Allergies (check all that apply)

☐ I have allergies to the following medications (please list): ______________________

☐ Allergy to Latex ______________________

☐ Allergy to Adhesives ______________________

☐ Allergy to Lidocaine or numbing medication ______________________

☐ No allergies to medications

Do you have any of the following symptoms?

Fever or chills	☐ No	☐ Yes	Abdominal pain	☐ No	☐ Yes
Night sweats	☐ No	☐ Yes	Nausea or vomiting	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes	Constipation or diarrhea	☐ No	☐ Yes
Unexplained weight loss	☐ No	☐ Yes	Joint pain	☐ No	☐ Yes
Swollen lymph nodes	☐ No	☐ Yes	Rash or itchy skin	☐ No	☐ Yes
Headaches	☐ No	☐ Yes	Problems with scarring	☐ No	☐ Yes
Blurry vision	☐ No	☐ Yes	Seasonal allergies	☐ No	☐ Yes
Chronic cough	☐ No	☐ Yes	Immunosupression	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes	Blood thinners	☐ No	☐ Yes
Chest pain	☐ No	☐ Yes	Blood clots	☐ No	☐ Yes
Artificial heart valve	☐ No	☐ Yes	Pre-medicate prior to procedures	☐ No	☐ Yes
Pacemaker or defibrillator	☐ No	☐ Yes	Pregnancy or planning a pregnancy?	☐ No	☐ Yes

Other Symptoms: ______________________

Is there anything else in your history that we should be aware of?

____

Signature of Patient (or Guardian) ______________________ **Date**: ______________

If signed by a guardian, please describe the relationship to the patient: ______________