Medical History Form

Name _____ Date of Birth ____/_____/_____

How did you hear about our practice? _____ Primary care doctor _____

Preferred Pharmacy _____ **Location** _____

What is the reason for your visit today? _____

Please note, during a skin cancer screening, it is difficult to address additional skin conditions adequately in the time allotted. Additional issues may require additional visits.

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

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autoimmune disease
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Bleeding disorder
- ☐ Colon Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Kidney disease
- ☐ GERD or reflux
- ☐ Hearing loss
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ HSV/cold sores
- ☐ High Cholesterol
- ☐ Thyroid disease
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Organ transplant
- ☐ Radiation treatment
- ☐ Seasonal Allergies
- ☐ Stroke
- ☐ Other Cancer _____
- ☐ Any other conditions? _____

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

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Eczema
- ☐ Flaking or itchy scalp
- ☐ Hair loss
- ☐ Melanoma
- ☐ Precancerous moles
- ☐ Psoriasis
- ☐ Squamous cell carcinoma
- ☐ Other _____

Medications

Name	Dose and frequency	Purpose

Medication or Other Medical Allergies (check all that apply)

☐ **No allergies to medications**

☐ I have an allergy to the following medications (please list)

Name _____ Reaction _____

_____ _____

Social History

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

Alcohol use ☐ No ☐ Socially ☐ moderate ☐ heavy

Occupation _____

Family History

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

Other family history of significance? _____

Do you have any of the following symptoms at this time?

Fever or chills	☐ No	☐ Yes	Chest pain	☐ No	☐ Yes
Night sweats	☐ No	☐ Yes	Abdominal pain	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes	Nausea or vomiting	☐ No	☐ Yes
Unexplained weight loss	☐ No	☐ Yes	Constipation or diarrhea	☐ No	☐ Yes
Swollen lymph nodes	☐ No	☐ Yes	Joint pain	☐ No	☐ Yes
Headaches	☐ No	☐ Yes	Rash or itchy skin	☐ No	☐ Yes
Blurry vision	☐ No	☐ Yes	Problems with healing (keloids)	☐ No	☐ Yes
Chronic cough	☐ No	☐ Yes	Immunosupression	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes	Blood clots	☐ No	☐ Yes

Other Symptoms: _____

Medical Alerts Do you have any of the following?

Allergy to adhesives	☐ Yes	☐ No
Allergy to lidocaine	☐ Yes	☐ No
Allergy to topical antibiotics	☐ Yes	☐ No
Artificial heart valve	☐ Yes	☐ No
Pacemaker or defribillator	☐ Yes	☐ No
Blood thinners	☐ Yes	☐ No
Premedication prior to procedures	☐ Yes	☐ No

Women Only

Pregnant or planning a pregnancy	☐ Yes	☐ No
Breastfeeding	☐ Yes	☐ No
Oral contraceptive	☐ Yes	☐ No

Other birth control _____

Is there anything else you would like us to be aware of?

_____

Signature of Patient (or Guardian) _____ **Date**: _____

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