Medical History

Patient Name: _____ Date of Birth: _____

Email:_____

Reason for Visit: _____

How long have you had this issue?: _____

What are your symptoms?: _____

How does this bother you?: _____

Treatments you have tried: _____

Past Medical History:

_____No Pertinent Past Medical History

_____ Anemia	_____ Asthma	_____ Bleeding Disorder	_____ Thyroid Disorder
_____ Cancer: Type_____		_____ Depression	_____ Diabetes
_____ Eczema	_____ Heart Disease	_____ Heart Murmur	_____ Hepatitis
_____ HIV	_____ Kidney Stones	_____ High Blood Pressure	_____ Pacemaker
_____ Lupus	_____ Stroke	_____ Long Term Steroid User	Other_____

Past Surgical History:

Surgery:_____ Date: _____ Complications: _____

Surgery:_____ Date: _____ Complications: _____

Previous Skin History:

History of Skin Cancer?: Yes_____ No_____ (Basal Cell, Squamous Cell, Melanoma, Dysplasia, Actinic Keratosis, etc.)

If 'Yes': Type: _____ Treatment: _____ Date: _____

Sun Exposure:

_____ Always Burn	_____ Usually Burn, Rarely Tan	_____ Often Burn, Tan Slowly
_____ Sometimes Burn, Tan Well	_____ Rarely Burn, Always Tan	_____ Never Burn, Deeply Tan

Current Skin Care Regimen: (Cleansers, Toners, Moisturizers, SPF, etc.)

_____

Previous Dermatology/Cosmetic Treatments: _____

Medical History Cont.

Past Family Medical History:

*Please list family member and specify Maternal/Paternal

Abnormal Bleeding_____ Diabetes_____ Liver Disease _____

Abnormal Clotting_____ Endocrine Disease_____ Lung Cancer_____

Adopted _____ Heart Disease_____ Malignant Melanoma_____

Autoimmune Disorders_____ Hemophilia_____ Other Cancer _____

Brain Tumor_____ High Blood Pressure_____ Skin Disease_____

Breast Cancer_____ Kidney Disease _____ Von Willebrand_____

Patient Allergies: _____

Current Medications: _____

_____

_____

Social History:

Alcohol: _____ No Alcohol Use _____ Uses Alcohol Use Socially _____ Uses Alcohol Use Daily

Drugs: _____ Does Not Use Illegal Drugs _____ Admits to Using Illegal Drugs

Marijuana: ____No Marijuana Use ____Admits Marijuana Use

STD: _____ No STD History _____ Admits STD History

High Risk Factors: _____ No High Risk Factors _____ Admits High Risk Factors

Smoking History: _____ Never Smoker

_____ Current Tobacco Smoker _____ Packs per Day _____Duration of Time as a Smoker

_____ Current Smokeless Tobacco User (i.e. Chew, snuff, etc.)

_____ Previous Smoker but quit _____ years/months ago

Race: _____ Ethnicity: _____ Preferred Language: _____

Basic Information:

Height: _____ Weight: _____

I, _____, verify that the information I have provided is accurate and complete to the best of my knowledge.

Signature: _____ Date: _____