Medical History Form: *Please answer all questions and sign at the bottom of the 3rd page*

Patient name _____ Date_____
Date of Birth_____
Primary Care Physician: _____
How did you hear about us? _____
Reason for today's visit_____
_____
_____
Duration of the condition _____
Medications tried for this condition _____
_____
_____
List all medications that you take (prescription and over-the-counter) _____
_____
_____
_____
Allergies to medications _____
Any problems with ▢Latex ▢Novocaine/lidocaine ▢Adhesive/band-aids ▢Iodine?
List past skin conditions_____
_____
▢ Psoriasis ▢ Lupus ▢ Eczema ▢ Hives ▢ Hay fever ▢ Asthma
List past skin cancers_____
▢ Actinic Keratoses ▢ Basal cell cancer ▢ Squamous cell cancer ▢ Melanoma
Have you ever had any abnormal moles? _____
List past medical conditions _____
_____
List any surgeries you have had _____
_____
Do you have a pacemaker or defibrillator? _____
Do you have artificial joints or implants? _____
Do you have artificial heart valves or heart valve disease? _____
Do you have an organ transplant? _____
Do you need pre-medication with antibiotics for dental work or surgery? _____
SKIN
When you are exposed to the sun do you ▢ always burn; extremely sun sensitive?
▢ burn easily; then tan a little?
▢ tan slowly; sometimes burn?
▢ always tan; burn a little?
▢ tan well; rarely burn?
▢ never burn?
▢Yes ▢no -Do you have abnormal scarring? _____
▢Yes ▢no -Do you have unusual reactions to sun exposure? _____
▢Yes ▢no -Chronic fever _____
▢Yes ▢no -Chills/sweats _____
▢Yes ▢no -Unexplained weight change _____
▢Yes ▢no -Weakness/fatigue _____
▢Yes ▢no -Headaches _____
▢Yes ▢no -Eye problems _____

▢Yes ▢no -Ear/Nose/Throat problems _____
▢Yes ▢no -Lung problems _____
▢Yes ▢no -Asthma_____
▢Yes ▢no -Cardiovascular problems _____
▢Yes ▢no -High blood pressure _____
▢Yes ▢no -Chest pain_____
▢Yes ▢no -Leg swelling_____
▢Yes ▢no -Heart attacks_____
▢Yes ▢no -Heart murmur_____
▢Yes ▢no -Irregular heart beat_____
▢Yes ▢no -Gastrointestinal problems_____
▢Yes ▢no -Nausea/vomiting/diarrhea_____
▢Yes ▢no -Hepatitis_____
▢Yes ▢no -Kidney/bladder problems_____
▢Yes ▢no -Thyroid disease_____
▢Yes ▢no -Diabetes (excessive thirst/hunger) _____
▢Yes ▢no -Arthritis/joint deformity _____
▢Yes ▢no -Joint pain _____
▢Yes ▢no -Limited motion _____
▢Yes ▢no -Blood or lymph disease _____
▢Yes ▢no -Blood clots _____
▢Yes ▢no -Bleeding problems _____
▢Yes ▢no -Convulsions/epilepsy/seizures _____
▢Yes ▢no -Fainting _____
▢Yes ▢no -Depression _____
▢Yes ▢no -Psychiatric illness _____
Do you have any disease not listed above? _____

Family History:
Has a family member had skin cancer (who/type)? _____
Do any blood relatives have **skin conditions** that run in the family? _____
Do any blood relatives have any other conditions that run in the family?
_____
_____

Women:
Are you on any form of oral, injectable or implantable contraceptives? _____
Are you pregnant or trying to become pregnant? _____ Due Date: _____
Are you nursing? _____
Do you get yeast infection when taking antibiotics? _____

Social History:
Do you wear sunscreen daily? _____ If yes, what SPF: _____
Have you ever used a tanning bed? Y /N Lifetime frequency (circle one): 1-10 10-20 20+
Have you ever had a blistering sunburn? Y / N

What is/was your occupation? _____
What are your hobbies? _____

Do you drink alcohol? _____ If yes, how many drinks per day? _____
Do you smoke cigarettes? _____ If yes, how many per day? _____
Do you currently chew tobacco? _____ Have you chewed in the past? _____
Do you use illicit drugs? _____ If so, what type and how often? _____

Pharmacy Information:
Name: _____ Phone: _____ Fax: _____

_____ _____
Patient Signature Date