Medical History Form

NAME: _____

Who is your primary care physician? _____

What skin concern brought you to the office today?_____

Past Medical History

Please circle all that apply

Anxiety
Arthritis
Asthma
Atrial fibrillation(irregular heartbeat)
Bone Marrow - transplanation
BPH
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

Surgical History:

Please circle all that apply

Appendix (Appendectomy)
Bladder (Cystectomy)
Breast: Biopsy - Right/Left
Lumpectomy - Right/Left
Mastectomy - Right/Left

Surgical History continued

Colon (Colectomy):
Cancer
Diverticulitis
Inflammatory Bowel Disease
Colostomy
Gallbladder - Cholecystectomy
Heart:
Valve Replacement
Biological/Mechanical
Coronary Artery Bypass
Transplant
PTCA
Joint Replacement:
Hip / Knee / Other
Kidney: Kidney Biopsy
Kidney Stone Removal
Kidney Transplant
Nephrectomy
Liver: Hepatectomy
Liver Transplant
Shunt
Ovaries: Oophorectomy
Endometriosis
Cancer
Cyst
Tubal Ligation
Pancreas: Pancreatectomy
Prostate: Biopsy
Cancer
TURP
Skin: Basal Cell Carcinoma
Melanoma
Skin Biopsy
Squamous Cell Carcinoma
Other
Spleen - Splenectomy
Testicles - Orchiectomy
Uterus - Hysterectomy
Cervical Cancer
Fibroids
Uterine Cancer

Derm History: (Please Circle) Acne

Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Other
Poison Ivy
Precancerous Moles
Psoriasis
Squamous cell skin cancer

Review of Systems: (Please circle)

Fever/chills
Problems with healing
Problems with scarring (hypertroph keloid)
Problems with bleeding

Cigarette Smoking: (Please Circle)

Never Smoked
Quit: former smoker
Smokes less than daily
Smokes daily
Packs per day:_____
Years smoking:_____

Alcohol Use: (Please Circle)

None
Less than 1 per day
1-2 drinks per day
3 or more per day

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Emergency Contact - Please Print Phone Number

Patient's Signature _____ Date_____