

**PATIENT HISTORY**

PLEASE PRINT CLEARLY Date \_\_\_\_\_

Name \_\_\_\_\_ Check One:  Female  Male Age \_\_\_\_\_

Date of Birth (MONTH/DAY/YEAR) \_\_\_\_\_ Are you:  Single  Married  Widowed

Were you referred by a physician?  No  Yes

Name of referring physician \_\_\_\_\_

Please state nature, location and duration of skin problem \_\_\_\_\_

Previous treatments? \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**PERSONAL MEDICAL/SURGICAL HISTORY**

**Past Medical History (please check all that apply)**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anxiety                     | <input type="checkbox"/> Depression              | <input type="checkbox"/> Hypothyroidism      |
| <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Leukemia            |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Lung Cancer         |
| <input type="checkbox"/> Atrial fibrillation         | <input type="checkbox"/> GERD                    | <input type="checkbox"/> Lymphoma            |
| <input type="checkbox"/> Bone Marrow Transplantation | <input type="checkbox"/> Hearing Loss            | <input type="checkbox"/> Prostate Cancer     |
| <input type="checkbox"/> BPH                         | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Breast Cancer               | <input type="checkbox"/> Hypertension            | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Colon Cancer                | <input type="checkbox"/> HIV/AIDS                | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> COPD                        | <input type="checkbox"/> Hypercholesterolemia    | <input type="checkbox"/> None                |
| <input type="checkbox"/> Coronary Artery Disease     | <input type="checkbox"/> Hyperthyroidism         |  |

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Past Surgical History (please check all that apply)

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Appendix Removed                       | <input type="checkbox"/> Coronary Artery Bypass                           | <input type="checkbox"/> Liver Shunt                       | <input type="checkbox"/> Rectum: Low Anterior Resection             |
| <input type="checkbox"/> Bladder Removed                        | <input type="checkbox"/> PTCA   | <input type="checkbox"/> Liver Transplant                  | <input type="checkbox"/> Skin Biopsy                                |
| <input type="checkbox"/> Mastectomy (Right, Left, Bilateral)    | <input type="checkbox"/> Mechanical Valve Replacement                     | <input type="checkbox"/> Liver Removed                     | <input type="checkbox"/> Basal Cell Carcinoma Surgery               |
| <input type="checkbox"/> Lumpectomy (Right, Left, Bilateral)    | <input type="checkbox"/> Biological Valve Replacement                     | <input type="checkbox"/> Ovaries Removed: Endometriosis    | <input type="checkbox"/> Squamous Cell Carcinoma Surgery            |
| <input type="checkbox"/> Breast Biopsy (Right, Left, Bilateral) | <input type="checkbox"/> Heart Transplant                                 | <input type="checkbox"/> Ovaries Removed: Cyst             | <input type="checkbox"/> Melanoma Surgery                           |
| <input type="checkbox"/> Breast Reduction                       | <input type="checkbox"/> Joint Replacement, Knee (Right, Left, Bilateral) | <input type="checkbox"/> Ovaries Removed: Ovarian Cancer   | <input type="checkbox"/> Spleen Removed                             |
| <input type="checkbox"/> Breast Implants                        | <input type="checkbox"/> Joint Replacement, Hip (Right, Left, Bilateral)  | <input type="checkbox"/> Ovaries: Tubal Ligation           | <input type="checkbox"/> Testicles Removed (Right, Left, Bilateral) |
| <input type="checkbox"/> Colectomy: Colon Cancer Resection      | <input type="checkbox"/> Joint Replacement within last 2 years            | <input type="checkbox"/> Pancreas Removed                  | <input type="checkbox"/> Hysterectomy: Fibroids                     |
| <input type="checkbox"/> Colectomy: Diverticulitis              | <input type="checkbox"/> Kidney Biopsy                                    | <input type="checkbox"/> Prostate Removed: Prostate Cancer | <input type="checkbox"/> Hysterectomy: Uterine Cancer               |
| <input type="checkbox"/> Colectomy: IBD                         | <input type="checkbox"/> Kidney Removed (Right, Left)                     | <input type="checkbox"/> Prostate Biopsy                   | <input type="checkbox"/> Hysterectomy: Cervical Cancer              |
| <input type="checkbox"/> Colon: Colostomy                       | <input type="checkbox"/> Kidney Stone Removal                             | <input type="checkbox"/> TURP                              | <input type="checkbox"/> None                                       |
| <input type="checkbox"/> Gallbladder Removed                    | <input type="checkbox"/> Kidney Transplant                                | <input type="checkbox"/> Rectum: APR                       |   |

Other: \_\_\_\_\_

### Skin Disease History (please check all that apply)

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Acne                   | <input type="checkbox"/> Blistering Sunburns    | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Psoriasis                 |
| <input type="checkbox"/> Actinic Keratoses      | <input type="checkbox"/> Dry Skin               | <input type="checkbox"/> Melanoma            | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Eczema                 | <input type="checkbox"/> Poison Ivy          | <input type="checkbox"/> None                      |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Precancerous Moles  |  |

Other: \_\_\_\_\_

Do you wear sunscreen?  No  Yes If yes, what SPF? \_\_\_\_\_

Do you tan in a tanning salon?  No  Yes Do you have a family history of Melanoma?  No  Yes

If yes, which relative(s)? \_\_\_\_\_

## MEDICATIONS

List present medications and dosage (including non-prescription and birth control pills):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

## ALLERGIES

Are you allergic to any medications?  No  Yes (if yes, specify below)

MEDICATION

REACTION

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

## SOCIAL HISTORY

(please check all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Currently smokes — daily     | <input type="checkbox"/> Former smoker | <input type="checkbox"/> Drug use          |
| <input type="checkbox"/> Currently smokes — not daily | <input type="checkbox"/> Never smoked  | <input type="checkbox"/> None of the above |

Occupation: \_\_\_\_\_

Other: \_\_\_\_\_

## REVIEW OF SYSTEMS

(please check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Unintentional weight loss         | <input type="checkbox"/> Stomach upset with antibiotics | <input type="checkbox"/> History of melanoma              |
| <input type="checkbox"/> Headaches                         | <input type="checkbox"/> Abdominal pain                 | <input type="checkbox"/> Transplant recipient             |
| <input type="checkbox"/> Persistent cough                  | <input type="checkbox"/> Depression                     | <input type="checkbox"/> Immunosuppression                |
| <input type="checkbox"/> Artificial heart valve            | <input type="checkbox"/> Anxiety                        | <input type="checkbox"/> Antibiotic before surgery        |
| <input type="checkbox"/> CPAP                              | <input type="checkbox"/> Bloody stools                  | <input type="checkbox"/> Dialysis                         |
| <input type="checkbox"/> History of fever blisters         | <input type="checkbox"/> Bloody urine                   | <input type="checkbox"/> Implanted defibrillator          |
| <input type="checkbox"/> Atypical mole(s)                  | <input type="checkbox"/> Blurry vision                  | <input type="checkbox"/> Pacemaker                        |
| <input type="checkbox"/> CABG                              | <input type="checkbox"/> Fever or chills                | <input type="checkbox"/> Recent chest pain                |
| <input type="checkbox"/> Bleeding problems                 | <input type="checkbox"/> Joint pain                     | <input type="checkbox"/> Oxygen use daily                 |
| <input type="checkbox"/> Wound healing problems            | <input type="checkbox"/> Muscle weakness                | <input type="checkbox"/> Blood thinners                   |
| <input type="checkbox"/> Scarring problems                 | <input type="checkbox"/> Neck stiffness                 | <input type="checkbox"/> Pregnant (or planning pregnancy) |
| <input type="checkbox"/> Rash                              | <input type="checkbox"/> Night sweats                   | <input type="checkbox"/> Seizures                         |
| <input type="checkbox"/> Shortness of breath               | <input type="checkbox"/> Sore throat                    | <input type="checkbox"/> Latex Allergy                    |
| <input type="checkbox"/> Wheezing                          | <input type="checkbox"/> Thyroid problems               | <input type="checkbox"/> Local Anesthetic Allergy         |
| <input type="checkbox"/> Yeast infections with antibiotics |   |   |

Reviewed \_\_\_\_\_

Revised \_\_\_\_\_