

Medical History Form

Please fill out both sides of the questionnaire

Name _____ Date of birth _____ Age _____

How did you hear about us? Internet Phone book Friend Medical provider – name _____

What is the reason for your visit today? How long has condition been present? Prior treatments?

List current medications (prescription and over-the-counter): None

Please attach separate list if needed

List allergies to medications: None

Problems with the following? Latex Local anesthetics Epinephrine Tape/band-aids Topical antibiotics

Are you on blood thinners? No Aspirin Ibuprofen Coumadin Vit E Plavix Other: _____

Do you need pre-medication with antibiotics for dental work or surgery? Yes No

Please check if you have a personal or family history of the following skin conditions:

	PERSONAL HISTORY	FAMILY HISTORY (please list relation)
Eczema	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Psoriasis	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Acne	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Abnormal scars	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Abnormal moles	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Precancerous growths	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Skin cancer (list type)	<input type="checkbox"/> _____	<input type="checkbox"/> _____

How does your skin react to sun exposure? Always burn, never tan
 Burn easily, then tan a little
 Tan slowly, sometimes burn

Tan well, rarely burn
 Never burn

Do you now or in the past use tanning beds routinely? No Yes

Do you tan outdoors? No Yes

Do you get a rash or other skin reaction to the sun? No Yes

Do you wear sunscreen? No Yes

Do you do any of the following to protect your skin? Wear a hat
 Wear sunglasses

Wear sun protective clothing
 Avoid mid-day sun

Do you take multivitamins? No Yes If yes, do you take extra vitamin D? _____

Please turn over and complete reverse side

Do you have now or in the past any of the following? If yes, please explain.

- No Yes Chronic fever or sweats _____
- No Yes Unexplained weight change _____
- No Yes Weakness/fatigue _____
- No Yes Cancer (other than skin) _____
- No Yes Headaches _____
- No Yes Eye problems _____
- No Yes Cold sores/mouth sores _____
- No Yes Hayfever _____
- No Yes Asthma _____
- No Yes Other breathing problems _____
- No Yes Hives _____
- No Yes High blood pressure _____
- No Yes High cholesterol _____
- No Yes Heart valve disease _____
- No Yes Pacemaker or defibrillator _____
- No Yes Nerve disease or stroke _____
- No Yes Leg swelling or varicose veins _____
- No Yes Gastrointestinal disease _____
- No Yes Hepatitis _____
- No Yes Kidney disease _____
- No Yes Thyroid disease _____
- No Yes Diabetes _____
- No Yes Arthritis or artificial joints _____
- No Yes Bleeding or clotting disorder _____
- No Yes Fainting _____
- No Yes Mental health disorder _____
- No Yes HIV or immunocompromised _____
- No Yes Organ transplants (list year) _____

Do you have any medical problems or conditions that are not listed above? _____

SOCIAL HISTORY

What is your occupation? _____ If student, what is your school and grade? _____

What are your hobbies? _____

Do you drink alcohol? No Yes If yes, how many drinks per day? _____

Do you smoke cigarettes? No Yes If yes, how many per day? _____

<p>WOMEN ONLY</p> <p>Are you on any birth control? <input type="checkbox"/> No <input type="checkbox"/> Yes, type _____</p> <p>Have you had a hysterectomy, tubal ligation or endometrial ablation? <input type="checkbox"/> No <input type="checkbox"/> Yes, type _____</p> <p>Are you pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes, due date? _____</p> <p>Trying to become pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Are you nursing? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Frequent yeast infections? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>CHILDREN UNDER 10</p> <p>Premature birth? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Food allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Concerns with growth? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Developmental concerns? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>
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Signature (parent or guardian if patient is under 18)	Date
Printed name (if filled out by someone other than patient)	Relationship
Signature of physician	Date