Medical History Form

Patient Label

dermatology CONSULTANTS

Name:_____ Date of Birth:_____/_____/_____
(Last, First, Middle Initial)

Primary Physician:_____ Referring Physician:_____

1. What is the reason for your visit today?

Concern:	Location:	Duration:	Prior Treatments:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. Past Medical History

Do you have a history of the following?

Adhesive tape allergy	□ Yes	□ No	Abnormal scars	□ Yes	□ No
Latex allergy	□ Yes	□ No	Poor wound healing	□ Yes	□ No
Local anesthetics allergy	□ Yes	□ No	HSV / cold sore	□ Yes	□ No
Epinephrine sensitivity	□ Yes	□ No	Eczema	□ Yes	□ No
Bacitracin allergy	□ Yes	□ No	Asthma	□ Yes	□ No
Neosporin allergy	□ Yes	□ No	Hay fever	□ Yes	□ No
Anticoagulant treatment	□ Yes	□ No	Heart disease	□ Yes	□ No
Bleeding disorders	□ Yes	□ No	Diabetes	□ Yes	□ No
Artificial joint	□ Yes	□ No	Kidney disease	□ Yes	□ No
Artificial heart valves	□ Yes	□ No	Thyroid disease	□ Yes	□ No
Pacemaker / defibrillator	□ Yes	□ No	Lupus	□ Yes	□ No
Mitral valve prolapsed	□ Yes	□ No	Arthritis	□ Yes	□ No
Immunosuppressed	□ Yes	□ No	Psoriasis	□ Yes	□ No
Organ transplant	□ Yes	□ No			
CLL Chronic leukemia	□ Yes	□ No			
Pre-op/pre-dental antibiotics	□ Yes	□ No			
Memory problems	□ Yes	□ No			
Fainting / syncope	□ Yes	□ No			
Hepatitis	□ Yes	□ No			
HIV positive	□ Yes	□ No			
MRSA	□ Yes	□ No			

3. Do you have a history of melanoma? □ Yes □ No

Do you have a history of other skin cancer(s)? □ Yes □ No

Details:_____

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

(*please attach a separate list if needed.*)

Medication:	Dose:	Medication:	Dose:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5.List Medication allergies: _____

_____

_____

Patient Label

6. FOR WOMEN ONLY (MEN CONTINUE TO QUESTION 7)

Are you pregnant? □ Yes □ No Due date:_____
Are you breastfeeding? □ Yes □ No
Are you on Birth Control? □ Yes □ No If yes, type/name _____
Do you have regular menstrual cycles? □ Yes □ No

7. Please list other known allergies: _____

_____

_____

8. Do you have a family history of melanoma? □ Yes □ No

Do you have a family history of other skin cancer(s)? □ Yes □ No

Type(s):_____

_____

_____

_____

9. Social History:

Occupation:_____

Do you use tobacco? □ Yes □ No type:_____

Alcohol consumption: □ none □ socially □ moderate □ heavy

Do you use sunscreen? □ none □ daily □ occasionally

Tanning bed use? □ none □ current □ previous

Do you have any medical problems or conditions that are not listed that we should be aware of? _____

_____

_____

_____

Hobbies:_____

11. Do you have any of the following symptoms?

Fever	□ Yes	□ No	Shortness of breath	□ Yes	□ No	Swollen lymph nodes	□ Yes	□ No
Chills	□ Yes	□ No	Nausea / vomiting	□ Yes	□ No			
Fatigue	□ Yes	□ No	Abdominal pain	□ Yes	□ No	Joint pain	□ Yes	□ No
Unintentional weight loss	□ Yes	□ No	Diarrhea	□ Yes	□ No	Rash / itch	□ Yes	□ No
			Constipation	□ Yes	□ No	Headache	□ Yes	□ No
Eye Irritation	□ Yes	□ No	Easy bruising	□ Yes	□ No	Anxiety	□ Yes	□ No
Chronic cough	□ Yes	□ No	Blood clots	□ Yes	□ No	Depression	□ Yes	□ No