Medical History

Patient Label Here

dermatology CONSULTANTS

Name: _____ Preferred name / nickname: _____ DOB : _____

Primary Care Physician: _____ Referring Physician: _____

1. What is the reason for your visit today? (Note: if > 3 concerns, an additional office visit may be needed)

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

2. Past Skin Cancer History: Do you have a **PERSONAL** history of:

Melanoma:	Y	N
Details: _____		
Other Skin Cancer (Basal cell, Squamous cell):	Y	N
Details: _____		
Atypical Moles (aka "dysplastic")	Y	N
Actinic Keratoses:	Y	N

3. Past Medical History

Cancer (other than skin cancer):	Y	N
Type/Date: _____		
Psoriasis	Y	N
Eczema / Asthma / Hay fever (circle)	Y	N
Lupus	Y	N
Heart disease	Y	N
Diabetes	Y	N
Depression / Anxiety (circle)	Y	N
Kidney disease	Y	N
Thyroid disease	Y	N
Rheumatoid arthritis	Y	N
Ulcerative colitis or Crohns	Y	N
Stomach ulcers	Y	N
Multiple sclerosis or Myasthenia gravis	Y	N
Parkinson's disease	Y	N
Flu Vaccine	Y	N
Date: _____		
Pneumonia Vaccine	Y	N
Date: _____		
Organ transplant:	Y	N
Type/Date: _____		
Leukemia / Lymphoma (circle)	Y	N
Cold sores	Y	N
Hepatitis (A, B, or C)	Y	N
HIV positive	Y	N
MRSA	Y	N
Anticoagulant treatment	Y	N
Bleeding disorder	Y	N
Blood clots / pulmonary embolism	Y	N
Artificial joint	Y	N
Type/Date: _____		
Pacemaker	Y	N
Defibrillator	Y	N
Artificial heart valve	Y	N
Mitral valve prolapse	Y	N
Pre-op / dental antibiotics	Y	N
Fainting with procedures	Y	N
Keloid scars	Y	N

Please list any other medical conditions or details that we should be aware of:

_____

_____

4. Please list all current medications & conditions being treated:

Medication:	Condition :	Medication:	Condition:	Medication:	Condition:
1._____	_____	4._____	_____	7. _____	_____
2._____	_____	5._____	_____	8. _____	_____
3._____	_____	6._____	_____	9. _____	_____
10._____	_____	11._____	_____	12. _____	_____

5. Please list all allergies:

_____

_____

6. For Females only : Are you currently pregnant? Y/N If yes, # weeks pregnant: _____ Due Date : _____

Are you currently breastfeeding? Y/N

(OVER)→

7. For Females Only (Males: continue to question #8):

Are you taking birth control / IUD / or any other form of contraception? Y N
Type: _____

Do you have regular menstrual cycles? Y N
For teenagers: at what age did your menstrual cycle start? _____

Are you currently trying or planning to become pregnant in the next year? Y N

8. Family History

Do you have a family history of melanoma? Y N not known

Details: _____

Do you have a family history of other (non-melanoma) skin cancer? Y N not known

Details: _____

Do you have a family history of psoriasis? Y N not known
Do you have a family history of eczema? Y N not known

9. Social history:

Occupation: _____

Tobacco use: Y N past

Alcohol: Occasional / Social >5 drinks / week None

Tanning bed use Y N past

Past blistering sunburns Y N

Sunscreen use Y N occasional

Hobbies: _____

10. Review of Systems:

Fever	Y	N	Shortness of breath	Y	N	Swollen lymph nodes	Y	N
Chills	Y	N	Nausea / Vomiting	Y	N	Joint pain	Y	N
Fatigue	Y	N	Abdominal pain	Y	N	Rash / Itch	Y	N
Unintentional weight loss	Y	N	Diarrhea	Y	N	Headache	Y	N
			Constipation	Y	N	Anxiety	Y	N
Eye irritation	Y	N	Easy bruising	Y	N	Depression	Y	N
Chronic cough	Y	N	Blood clots	Y	N			

Please list your preferred pharmacy: _____

_____

Please list any other physicians that you would like updated on your medical care:

1._____

2. _____

3._____