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

3. Past Medical History:

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

Sex assigned at birth:_____ Gender identity_____

(Data collected for providing healthcare only.)

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

_____

_____

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

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

5. Please list all allergies:

_____

_____

(OVER) →

6. For Patients Who Can Get Pregnant Only:

Are you currently pregnant? □ Y □ N If yes, # weeks pregnant: _____ Due Date:_____

Are you currently breastfeeding? □ Y □ N

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

7. 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

8. 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:_____

9. 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._____