dermatology CONSULTANTS

Medical History Form (REV 04.2025)

Patient Label Here

Name: _____ Preferred Name: _____ DOB: _____

Primary Care Physician: _____ Referring Physician: _____

1.What is the reason for your visit today?

Concern: _____ Body Location: _____ Duration: _____ Past Treatments: _____

2. Do you have a PERSONAL history of:

	Yes	No	
Melanoma	□	□	Details: _____
Basal cell or Squamous cell carcinoma	□	□	Details: _____
Pre-cancerous skin lesions	□	□	Details: _____

3. Past Medical History:

	Yes	No		Yes	No
Cancer (other than skin cancer): Type/Date: _____	□	□	Organ transplant: Type/Date: _____	□	□
Psoriasis	□	□	□ Leukemia / □ CLL	□	□
Eczema	□	□	Herpes simplex (cold sores)	□	□
Asthma	□	□	Hepatitis	□	□
Hay fever	□	□	HIV positive	□	□
Lupus	□	□	MRSA	□	□
Heart disease	□	□	Anticoagulant treatment	□	□
Diabetes	□	□	Bleeding disorder	□	□
□ Depression/□ Anxiety	□	□	□ Blood clots / □ Pulmonary embolism	□	□
Kidney disease	□	□	Artificial joint Type/Date: _____	□	□
Thyroid disease	□	□			
Rheumatoid arthritis	□	□	Artificial heart valve	□	□
Ulcerative colitis or Crohn's	□	□	Mitral valve prolapse	□	□
Stomach ulcers	□	□	Pre-op / dental antibiotics	□	□
Multiple sclerosis or Myasthenia gravis	□	□	Fainting with procedures	□	□
Parkinson's disease	□	□	Keloid Scars	□	□
Liver Disease	□	□	Pacemaker	□	□
Other Autoimmune Disease Please List: _____	□	□	Defibrillator	□	□

For patients under 18 years old: Height: _____ Weight_____

Any other medical conditions not listed above:

_____

4. Current medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

5. Allergies:

_____

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6. For Patients Who Can Get Pregnant:

	Yes	No	
Are you currently trying to get pregnant?	□	□	
Are you currently pregnant?	□	□	Due Date: _____
Are you currently breastfeeding?	□	□	
Are you taking birth control or have an IUD?	□	□	Type: _____
Do you have regular menstrual cycles?	□	□	

7. Family History:

	Yes	No	
Do you have a family history of melanoma?	□	□	Details: _____
Do you have a family history of other (non-melanoma) skin cancer?	□	□	Details: _____
Do you have a family history of psoriasis?	□	□	
Do you have a family history of eczema?	□	□	

8. The following information is collected for providing healthcare only.

Sex assigned at birth: □ Male □ Female

Gender identity: □ Male □ Female □ Transgender Male □ Transgender Female □ Non-binary □ Other: _____

Pronouns: □ She/her □ He/him □ They/them □ Other: _____

9. Social History:

Occupation: _____ Hobbies: _____

Tobacco use: □ Yes □ No □ Former

Alcohol: □ more than 4 drinks/day □ Occasional/Social □ None

Tanning Bed Use □ Yes □ No □ Past

Blistering Sunburns (Past) □ Yes □ No

Sunscreen Use □ Yes □ No

10. Review of Systems:

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

11. Preferred Pharmacy: _____