MEDICAL HISTORY FORM

Today's Date:	Primary Care Provider:	E-Mail:

PATIENT INFORMATION

Last Name: ________________________________ First Name: _________________________ Middle Initial: _____

Date of Birth: ____/____/____

Phone #:

Address:

Primary Language: ☐ English ☐ Arabic ☐ French ☐ German ☐ Mandarin ☐ Spanish ☐ Russian ☐ Other

Race: ☐ American Indian ☐ Asian ☐ African American or Black ☐ Native Hawaiian/Other Pacific ☐ White ☐ Unknown ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Primary Pharmacy: Address:

Prescription Benefits Provided By (i.e. Express Scripts, Medco, etc.):

REASON FOR TODAY'S VISIT

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

PAST MEDICAL HISTORY

CRITICAL INFORMATION

Adhesive tape / latex allergy	☐ Yes	☐ No
Anticoagulant treatment	☐ Yes	☐ No
Artificial heart valves	☐ Yes	☐ No
Artificial joint	☐ Yes	☐ No
Bacitracin / Neosporin allergy	☐ Yes	☐ No
Bleeding disorders	☐ Yes	☐ No
Breast cancer / Other cancer	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Epinephrine sensitivity	☐ Yes	☐ No
Fainting / syncope	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
HIV positivity	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Immunosuppressive therapy	☐ Yes	☐ No
Local anesthetics allergy	☐ Yes	☐ No
Lymphoma	☐ Yes	☐ No
Memory problems	☐ Yes	☐ No
Mitral valve prolapse	☐ Yes	☐ No
MRSA	☐ Yes	☐ No
Organ transplant	☐ Yes	☐ No
Pacemaker / defibrillator	☐ Yes	☐ No
Pre-op/pre-dental antibiotics	☐ Yes	☐ No

MEDICAL HISTORY

Abnormal moles	☐ Yes	☐ No
Abnormal scars	☐ Yes	☐ No
Acne	☐ Yes	☐ No
Actinic keratosis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Eczema	☐ Yes	☐ No
Hay fever	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No
HSV / cold sore	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No
Lupus	☐ Yes	☐ No
Multiple sclerosis	☐ Yes	☐ No
Parkinson's disease	☐ Yes	☐ No
Poor wound healing	☐ Yes	☐ No
Psoriasis	☐ Yes	☐ No
Rosacea	☐ Yes	☐ No
Seasonal allergies	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Warts	☐ Yes	☐ No
Other (specify below)	☐ Yes	☐ No

SKIN CANCER HISTORY	
Do you have a history of melanoma?	□ Yes □ No
Do you have a history of other skin cancer(s)?	□ Yes □ No
Type(s) / Location(s):	

CURRENT MEDICATIONS		
Medication:	Medication:	Medication:
Medication:	Medication:	Medication:
Medication:	Medication:	Medication:
Medication:	Medication:	Medication:

MEDICATION ALLERGIES	
Do you have any medication allergies:	□ Yes □ No
List allergies:	

FOR WOMEN ONLY	
Are you pregnant?	□ Yes □ No
Are you breastfeeding?	□ Yes □ No
Are you on birth control?	□ Yes □ No
Do you have regular menstrual cycles?	□ Yes □ No

FAMILY HISTORY OF SKIN CANCER	
Do you have a family history of melanoma?	□ Yes □ No
Do you have a family history of other skin cancer(s)?	□ Yes □ No
Types:	

SOCIAL HISTORY	
Occupation:	**Specify:**______________________________
Do you use sunscreen?	□ None □ Daily □ Occasionally
Tanning bed use?	□ None □ Current □ Previous
What are your hobbies?	
Do you have any other medical problems or conditions?	

TOBACCO		
Do you use tobacco?		□ Yes □ No
Please check on what applies below:		
Never smoker □	Light tobacco smoker □	Smoker, current status unknown □
Former smoker □	Currently every day smoker □	
Unknown if ever smoked □	Heavy tobacco smoker □	

ALCOHOL		
Alcohol consumption?		□ Socially □ Moderate □ Heavy
Please check on what applies below:		
Never □	2-3 / Week □	No screening □
Monthly or less □	4+ / Week □	Number of drinks, **Specify:**____________
2-4 / Month □	Medical exclusion □	

ADDITIONAL SYMPTOMS

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