PATIENT MEDICAL HISTORY

Date:

LAST NAME: FIRST Name: DOB: Male/Female

What is the **MAIN REASON** for your visit today?

Where is the location of the problem?
When did this current episode begin?
How long have you had this problem?
Have you had previous treatment for this condition in the past? Y/N *If yes answer the following:*
Over the Counter?
Prescription Oral Meds?
Prescription Topical Meds?

SKIN HISTORY: Do you now or have you ever had in the past any of the following?

Basal Cell Carcinoma? Y/N Squamous Cell Carcinoma? Y/N Melanoma? Y/N

Actinic Keratosis (AK)? Y/N Abnormal moles? Y/N

Circle if you currently have or had any of the following:

Abnormal scars/keloids Folliculitis Seborrheic dermatitis (dandruff) Rosacea

Acne Dry Skin Eczema

Liquid Nitrogen Biopsy Mohs Skin Surgery Light Therapy

When was your last clinical full body exam?

Are you allergic to any medications? No Yes Aspririn Codeine Penicillin Sulfa

Other:

Current Oral/Topical/Injectable Medications/None

Medication Name Condition Being Treated

Do you use any natural, herbal, alternative medicine, supplements?

Name Condition Being Treated

PAST MEDICAL HISTORY do you now or in the past have a history of any of the following?
Circle all that apply

HIV Positive lupus blood Clot Issue hemophilia bleeding disorder hepatitis

liver problems cancer cold sores dizziness/vertigo psychiatric problems herpes
irregular menses high blood pressure pacemaker leg ulcers artificial valve

diabetes thyroid problems sarcoidosis tuberculosis valley fever arthritis

multiple sclerosis seizure other:

FAMILY HISTORY Have your parents, grandparents, children or siblings have any of the following conditions: *Circle all that apply*

Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma other skin cancer

Abnormal moles lupus sarcoidosis psoriasis any other skin conditions

Which family member:

SOCIAL HISTORY

Do you smoke? Y/N Do you use any recreational or IV drugs? N/Y If yes, what?

What is your occupation?

Have you ever used a tanning booth? Y/N Laid out in the sun? Y/N Worked outside? Y/N

How many sunburns have you had?

Do you wear daily sunscreen? Y/N

Do you do self-skin exams? Y/N