

PATIENT HISTORY

PLEASE PRINT CLEARLY

Date _____

Name _____ Check One: ☐ Female ☐ Male Age _____

Date of Birth (MONTH/DAY/YEAR) _____ Are you: ☐ Single ☐ Married ☐ Widowed

Were you referred by a physician? ☐ No ☐ Yes

Name of referring physician _____

Please state nature, location and duration of skin problem _____

Previous treatments? _____

Pharmacy: _____ Address: _____ Phone: _____

PERSONAL MEDICAL/SURGICAL HISTORY

Past Medical History (please check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> GERD | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Bone Marrow Transplantation | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> BPH | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> None |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hyperthyroidism | |

Other: _____

Past Surgical History (please check all that apply)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Appendix Removed | <input type="checkbox"/> Coronary Artery Bypass | <input type="checkbox"/> Liver Shunt | <input type="checkbox"/> Rectum: Low Anterior Resection |
| <input type="checkbox"/> Bladder Removed | <input type="checkbox"/> PTCA | <input type="checkbox"/> Liver Transplant | <input type="checkbox"/> Skin Biopsy |
| <input type="checkbox"/> Mastectomy (Right, Left, Bilateral) | <input type="checkbox"/> Mechanical Valve Replacement | <input type="checkbox"/> Liver Removed | <input type="checkbox"/> Basal Cell Carcinoma Surgery |
| <input type="checkbox"/> Lumpectomy (Right, Left, Bilateral) | <input type="checkbox"/> Biological Valve Replacement | <input type="checkbox"/> Ovaries Removed: Endometriosis | <input type="checkbox"/> Squamous Cell Carcinoma Surgery |
| <input type="checkbox"/> Breast Biopsy (Right, Left, Bilateral) | <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Ovaries Removed: Cyst | <input type="checkbox"/> Melanoma Surgery |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Joint Replacement, Knee (Right, Left, Bilateral) | <input type="checkbox"/> Ovaries Removed: Ovarian Cancer | <input type="checkbox"/> Spleen Removed |
| <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Joint Replacement, Hip (Right, Left, Bilateral) | <input type="checkbox"/> Ovaries: Tubal Ligation | <input type="checkbox"/> Testicles Removed (Right, Left, Bilateral) |
| <input type="checkbox"/> Colectomy: Colon Cancer Resection | <input type="checkbox"/> Joint Replacement within last 2 years | <input type="checkbox"/> Pancreas Removed | <input type="checkbox"/> Hysterectomy: Fibroids |
| <input type="checkbox"/> Colectomy: Diverticulitis | <input type="checkbox"/> Kidney Biopsy | <input type="checkbox"/> Prostate Removed: Prostate Cancer | <input type="checkbox"/> Hysterectomy: Uterine Cancer |
| <input type="checkbox"/> Colectomy: IBD | <input type="checkbox"/> Kidney Removed (Right, Left) | <input type="checkbox"/> Prostate Biopsy | <input type="checkbox"/> Hysterectomy: Cervical Cancer |
| <input type="checkbox"/> Colon: Colostomy | <input type="checkbox"/> Kidney Stone Removal | <input type="checkbox"/> TURP | <input type="checkbox"/> None |
| <input type="checkbox"/> Gallbladder Removed | <input type="checkbox"/> Kidney Transplant | <input type="checkbox"/> Rectum: APR | |

Other: _____

Skin Disease History (please check all that apply)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Actinic Keratoses | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Poison Ivy | <input type="checkbox"/> None |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Precancerous Moles | |

Other: _____

Do you wear sunscreen? ☐ No ☐ Yes If yes, what SPF? _____

Do you tan in a tanning salon? ☐ No ☐ Yes Do you have a family history of Melanoma? ☐ No ☐ Yes

If yes, which relative(s)? _____

MEDICATIONS

List present medications and dosage (including non-prescription and birth control pills):

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

ALLERGIES

Are you allergic to any medications? ☐ No ☐ Yes (if yes, specify below)

MEDICATION

REACTION

1. _____
2. _____
3. _____
4. _____

SOCIAL HISTORY

(please check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Currently smokes — daily | <input type="checkbox"/> Former smoker | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Currently smokes — not daily | <input type="checkbox"/> Never smoked | <input type="checkbox"/> None of the above |

Occupation: _____

Other: _____

REVIEW OF SYSTEMS

(please check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Unintentional weight loss | <input type="checkbox"/> Stomach upset with antibiotics | <input type="checkbox"/> History of melanoma |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Transplant recipient |
| <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Depression | <input type="checkbox"/> Immunosuppression |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Antibiotic before surgery |
| <input type="checkbox"/> CPAP | <input type="checkbox"/> Bloody stools | <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> History of fever blisters | <input type="checkbox"/> Bloody urine | <input type="checkbox"/> Implanted defibrillator |
| <input type="checkbox"/> Atypical mole(s) | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> CABG | <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Recent chest pain |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Oxygen use daily |
| <input type="checkbox"/> Wound healing problems | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Blood thinners |
| <input type="checkbox"/> Scarring problems | <input type="checkbox"/> Neck stiffness | <input type="checkbox"/> Pregnant (or planning pregnancy) |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Local Anesthetic Allergy |
| <input type="checkbox"/> Yeast infections with antibiotics | | |

Reviewed _____

Revised _____