PLEASE C MPLETE THE FOLLOWING MED L HISTORY FORM

Name _____ Date _____

Referred by: ❑ M.D.: _____ ❑ Self/Friend

Date of Birth: _____ Age _____ Sex: ❑ M ❑ F

Main skin problem you want evaluated? _____

1. **Body area:** _____ **Duration:** _____
2. **Previous treatments (all medicines used):** ❑ None

_____

3. **Changes:** ❑none ❑ color ❑ size ❑ elevation ❑ hardness
4. **Modifying factors:** ❑ none ❑ history of sun exposure ❑ other immune diseases ❑ other illness
5. **Symptoms:** ❑none ❑ bleed ❑ itch ❑ pain ❑ infection
6. **Severity:** ❑ none ❑ occasional ❑ constant

Complete list of all other skin areas, growths, skin symptoms, or questions you have:

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

MEDICAL HISTORY ❑None Illness, surgeries, hospitalizations and dates: ❑ Continued on other side

List: _____

Current or past health problems:

❑ **None**

❑ Anemia ❑ Tuberculosis ❑ Heart Murmur ❑ Artificial Heart Valve
❑ Cancer ❑ Hepatitis ❑ Thyroid Disease ❑ Irreg. pulse/heartbeat
❑ Seizers ❑ Stroke ❑ Peptic ulcer disease ❑ Migraine Headaches
❑ Arthritis ❑ Depression ❑ Venereal Disease
❑ HIV/AIDS ❑ Diabetes ❑ Hypertension
❑ Asthma ❑ Hay Fever/Sinus ❑ Prostate Prob.
❑ Herpes ❑ Pacemaker ❑ Coronary Heart Disease
❑ Other medical (explain) _____
❑ Do you need antibiotics for dental work? ❑ Yes ❑ No

Current or past skin problems:

❑ **None**

❑ Eczema ❑ Rash
❑ Abnormal moles ❑ Hives
❑ Frequent sun exposures ❑ Melanoma
❑ Excessive scarring ❑ Psoriasis
❑ Recent or progressive hair loss
❑ Precancer spots (actinic Keratosis)
❑ Other skin cancer: _____

CURRENT MEDICATIONS All prescriptions, over-the-counter, vitamin and supplements (including herbal)

❑None

List: _____

PREGNANCY ❑ Yes ❑ No ❑ Current Contraceptive Methods: _____ ❑ N/A

ALLERGIES ❑ None

List: _____

FAMILY HISTORY

❑ None

❑ Melanoma ❑ Eczema ❑ Allergies ❑ Hay Fever ❑ Cancer ❑ Psoriasis ❑ Asthma ❑ Other Skin Cancer

❑ Other _____

SOCIAL HISTORY Occupation _____

Martial Status: ❑ S ❑ M ❑ D ❑ W

Smoking: ❑ No ❑ Former ❑ Yes: how many packs/day? _____

Alcohol: ❑ No ❑ Social/occasional drinking only

Alcohol or drug problems/addictions: ❑ No ❑ Yes ❑ Describe: _____

CURRENT SYMPTONS (check all that apply) ❑ None

❑ Fevers/chills/weight loss ❑ Headaches/visual hearing problems ❑ Heart/breathing problems ❑ Bone/joint pain
❑ Stomach/intestinal problems ❑ Urinary or kidney problems ❑ Sweats or hair loss ❑ Easy bruising
❑ Neurological/psychological problems ❑ Enlarged glands or bleeding problems
❑ Other skin symptoms, list: _____

_____ _____

Patient Signature Provider Signature