DERMATOLOGY and SKIN CANCER CENTER

MEDICAL HISTORY FORM

Name: _____ DOB: _____ SSN: _____

Phone: _____ Email: _____ Gender: MALE / FEMALE

May we leave a message on your voicemail? Yes / No Occupation/School: _____

Address _____

Emergency Contact: _____ Parent / Spouse / Friend / Other Phone: _____

Is it ok to release Medical Information to your Emergency Contact? Yes / No Initial: _____

Primary Care Physician Name / Practice: _____ Phone: _____

Height / Weight: _____ Preferred Pharmacy Number / Location: _____

General Medical History: Do you have or have you ever had any of the following?

Y	N	Acne	Y	N	Coronary Artery Disease	Y	N	Lung Cancer
Y	N	Actinic Keratoses	Y	N	Eczema	Y	N	Lymphoma
Y	N	Anxiety	Y	N	End Stage Renal Disease	Y	N	Melanoma
Y	N	Arthritis	Y	N	GERD	Y	N	Poison Ivy
Y	N	Asthma	Y	N	Hay fever / Allergies	Y	N	Precancerous Moles
Y	N	Atrial Fibrillation	Y	N	Hearing Loss	Y	N	Prostate Cancer
Y	N	Basal Cell Carcinoma	Y	N	Hepatitis	Y	N	Psoriasis
Y	N	Blistering sunburns	Y	N	HIV or AIDS	Y	N	Radiation Treatment
Y	N	Bone Marrow Transplant	Y	N	Hypercholesterolemia	Y	N	Seizures
Y	N	Breast Cancer	Y	N	Hypertension (HTN)	Y	N	Squamous Cell Carcinoma
Y	N	Colon Cancer	Y	N	Hyper / Hypothyroidism	Y	N	Stroke
Y	N	COPD	Y	N	Leukemia	Y	N	Other:

Surgeries (please indicate date):

Y	N	Appendix (Appendectomy)	Y	N	Joint Replacement (Type):	Y	N	Prostate
Y	N	Bladder (Cystectomy)				Y	N	Rectum APR
Y	N	Breast:	Y	N	Kidney	Y	N	Skin
Y	N	Colon (Colectomy or Colostomy)	Y	N	Liver	Y	N	Spleen
Y	N	Gallbladder (Cholecystectomy)	Y	N	Ovaries	Y	N	Uterus
Y	N	Heart (Type)	Y	N	Pancreas	Y	N	Other

* Are you currently pregnant, nursing, or planning to become pregnant?

Current Medications (including Prescription, Non-Prescription / Over the Counter, Vitamins, Herbs)

_____

Reaction / Allergy to medications and type of reaction (example: hives, difficulty breathing, swelling, etc)

_____

Social History: Tobacco use? Current / Former / Never Do you drink alcohol? Yes / No / Formerly

Marital status_____ Children _____ Hobbies _____

Family History: Circle any conditions affecting a blood relative. Specify who is affected below the circle.

Melanoma / Basal cell or squamous cell skin cancer / Psoriasis / Eczema / Hayfever or allergies / Asthma / Acne

Please indicate if you are interested in hearing more about any of the cosmetic products or procedures below:

- _____ Botox
- _____ Laser Procedures for:
  - ___ red spots ___ brown spots
- _____ Juvederm Dermal Filler
- _____ Chemical Peels
- ___ Latisse (Thicker Lashes)
- ___ Acne Extractions
- ___ Skin Care Products
  - ___ facials
  - ___ product consultation

How did you hear about us?

- __ Insurance website
- Internet Search:Google/Yahoo/Bing
- __ Newspaper/Mag
- __ Doctor Referral - Dr._____
- __ Patient Referral - _____
- __ Other _____

Signature of person filling out this form: _____ **Date:** _____

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