DERMATOLOGY and SKIN CANCER CENTER

Primary Care Provider: _____

Preferred Pharmacy / Location _____

PATIENT 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: _____

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

Y	N	Acne	Y	N	Diabetes: Type I Type II	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	Skin Tags: Painful Y N Bleeding Y N
Y	N	Colon Cancer	Y	N	Hyper / Hypothyroidism	Y	N	Squamous Cell Carcinoma
Y	N	COPD	Y	N	Keloids: Painful Y N	Y	N	Stroke
Y	N	Coronary Artery Disease	Y	N	Leukemia	Y	N	Other:

Surgeries (please indicate date):

Y	N	Appendix (Appendectomy)	Y	N	Joint Replacement (Type):	Y	N	Rectum APR
Y	N	Bladder (Cystectomy)	Y	N	Kidney	Y	N	Skin
Y	N	Breast:	Y	N	Liver	Y	N	Spleen
Y	N	Colon (Colectomy or Colostomy)	Y	N	Ovaries	Y	N	Uterus
Y	N	Gallbladder (Cholecystectomy)	Y	N	Pancreas	Y	N	Other
Y	N	Heart (Type)	Y	N	Prostate	Current Height:		
* Are you currently pregnant, nursing, or planning to become pregnant?						Current Weight:		

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)

_____

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

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

Marital status _____ Children _____ Hobbies _____

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:** _____

Rev 9/18