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:** ____________

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