Patient Medical History

Name_____ Date of Birth _____

Occupation _____ Primary Care Physician _____

Why are you here today? _____
What prior treatments have you received? _____
How long have you had the problem? _____
Have you had it before? When? How often? _____
What part(s) of your body are affected? _____

CURRENT MEDICATIONS: (include prescription and non-prescription drugs, vitamins, creams)

_____

_____

ALLERGIES - MEDS: **None / Yes (list) _____**

Environmental? ___ latex ___ Bandaid ___ topical antibiotics ___ pollens ___ dust ___ pet dander

YOUR OWN PERSONAL MEDICAL HISTORY Please CIRCLE if you have a history of:

Skin Cancer	Melanoma	Precancer (AK)	Abnormal Moles	Easy bruising/bleeding
Asthma	Eczema	Keloid scars	Lupus	Hay Fever/Allergies
Thyroid	Diabetes	Psoriasis	Joint Replacement	Hepatitis
Radiation	Pacemaker	Organ Transplant	Other: _____	
Blistering sunburn	Occupational Sun Exposure:	Lifeguard	Construction	Landscaping Boating

If female: Are you pregnant? _____ Yes _____ No **Breast feeding: _____ Yes _____ No**

Recent surgical procedures: _____

Any recent hospitalizations or major illness? ___ Yes / ___ No (list) _____

FAMILY HISTORY: Please indicate if there is a family history of the following:

___Melanoma ___Psoriasis ___Allergies ___Lupus ___Abnormal moles

SOCIAL HISTORY:

Cigarette smoking: Never Current Former

Alcohol Use (daily): None Less than one One-two drinks 3 or more drinks

Tanning Bed Use: Never Current Former: less than 20 times 20-50 times more than 50

How many people live in your household? _____

What hobbies do you have? _____

Patient/Parent Signature _____ Date _____