

## Patient Medical History

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**DOB:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

*Please answer all questions to the best of your knowledge. This insures the best patient care and proper documentation.*

**Please list your drug allergies:**

\_\_\_\_\_

\_\_\_\_\_

**Please list current prescription and over the counter medications that you take:**

\_\_\_\_\_

\_\_\_\_\_

**Have you ever had any of the following?**

Asthma/Allergies (respiratory condition)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding problems (Are you on blood thinners?)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker or Defibrillator	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Rash to foods/plants	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stent, bypass, or mitral valve prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weight Gain/Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Yeast infections when taking antibiotics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Keloids (difficulty healing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Joint Replacement (hip/knee/shoulder	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

**Skin Cancers:**

Basal Cell Carcinoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Malignant Melanoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Squamos Cell Carcinoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, what level/stage _____	Year _____	
Are you pregnant or planning to become pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you take antibiotics before minor procedures such as dental work?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

**Has anyone in your family had any of the following skin cancers?**

Basal Cell Carcinoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Malignant Melanoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Squamos Cell Carcinoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, what level/stage _____	Year _____	

**Please list any other health-related conditions not previously identified:**

\_\_\_\_\_

\_\_\_\_\_

**Reason for today's visit (chief complaint):**

\_\_\_\_\_

**Have you had a comprehensive skin screening within one year (examination of moles, etc.)?** Yes No

**Medical Asst. Initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Physician Initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_