

Dermatology Adult Medical History Form

It is important to us that we provide you with the best care and service possible. Therefore, we ask that you complete this form so it can be reviewed by your health care provider. Please take the time to answer each question as accurately and completely as possible. The information you share may be helpful in determining your medical treatment. This form will be kept as part of your permanent medical record.

Name:		Date:	
Current Health Concerns:		Past Medical History	
1. Describe concern or condition		Medical Conditions: Please <u>circle</u> any of the following that apply to you and then <u>describe</u> .	
2. Location: Where did it first appear?		1. Previous skin cancer - basal cell carcinoma(s) squamous cell carcinoma(s)	
3. Present for how long?			
4. Is there a known possible cause?		2. Previous melanoma	
5. What have you used to treat to date?		3. Other Cancers	
6. What if anything has helped?		4. Asthma	
7. Please list your Current Medications:		5. Seasonal allergies	
8. What are your Current Allergies?		6. Other Conditions	
Previous Surgeries and Hospitalizations		Your Family History	
Please provide information about surgeries you have had for any skin cancers or other conditions		What diseases or conditions run in your family?	
1. Skin cancer surgeries <u>Year</u> (Please indicate if Mohs performed)		Please <u>circle</u> any of the following that apply, describe briefly and indicate the <u>relative</u> that had this condition.	
2. Previous surgeries/hospitalizations <u>Year</u>		1. Melanoma	
		2. Other skin cancers	
		3. Seasonal allergies	
		4. Asthma	
		5. Other skin conditions	

Personal Health Review

Please check or add any health problem(s) that you have had in the past 6 months.

General:	Skin	Hematologic/Lymphatic
<input type="checkbox"/> none	<input type="checkbox"/> normal	<input type="checkbox"/> normal
<input type="checkbox"/> unintentional weight loss	<input type="checkbox"/> keloids	<input type="checkbox"/> anemia (low blood count)
<input type="checkbox"/> fever	<input type="checkbox"/> poor healing	<input type="checkbox"/> bleeding problems
<input type="checkbox"/> difficulty swallowing	<input type="checkbox"/> other skin disorders	<input type="checkbox"/> enlarged lymph nodes
<input type="checkbox"/> special diet		<input type="checkbox"/> other:
<input type="checkbox"/> other:		

Cardiovascular	Respiratory	Gastrointestinal
<input type="checkbox"/> normal	<input type="checkbox"/> normal	<input type="checkbox"/> normal
<input type="checkbox"/> angina	<input type="checkbox"/> asthma	stomach ulcer
<input type="checkbox"/> artificial heart valve	<input type="checkbox"/> emphysema	<input type="checkbox"/> colitis (bowel inflammation)
<input type="checkbox"/> pacemaker	<input type="checkbox"/> other lung problem:	<input type="checkbox"/> other stomach problem:
<input type="checkbox"/> heart attack (when?)		

Neurological	Psychiatric	Endocrine
<input type="checkbox"/> normal	<input type="checkbox"/> normal	<input type="checkbox"/> normal
<input type="checkbox"/> stroke	<input type="checkbox"/> depression	<input type="checkbox"/> diabetes
<input type="checkbox"/> seizures	<input type="checkbox"/> anxiety attacks	<input type="checkbox"/> thyroid problems
<input type="checkbox"/> other:	<input type="checkbox"/> other:	<input type="checkbox"/> other:

Eyes/Ears/Nose/Throat	Musculoskeletal	Infections:
<input type="checkbox"/> normal	<input type="checkbox"/> normal	<input type="checkbox"/> none
<input type="checkbox"/> glaucoma	<input type="checkbox"/> arthritis	<input type="checkbox"/> hepatatis
<input type="checkbox"/> hearing aid	<input type="checkbox"/> artificial joint	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> cosmetic surgery	<input type="checkbox"/> Is your physical activity limited? If yes, please describe.	<input type="checkbox"/> tuberculosis (T.B.)
<input type="checkbox"/> other:	<input type="checkbox"/> other:	<input type="checkbox"/> other:

Sun exposure

Have you had extensive sun exposure? Yes _____ No _____
 How many blistering sunburns have you had? _____
 Do you wear sunscreen? Yes _____ No _____
 Daily use of sunscreen? Yes _____ No _____
 What SPF? _____

Your Social History

1. Are you working now? Yes _____ No _____
2. What is (or was) your occupation?
3. Do you use tobacco? Yes _____ Amount _____ No _____ Date Quit: _____
4. Do you use alcohol? Yes _____ No _____ If yes, type and amount used.
5. Do you or have you used street drugs? Yes _____ No _____ If yes, type and amount used.