



Established Patient Medical History Form

Patient: _____ Date of Birth: _____ Date of Visit: _____

Address: _____ Ins Co: _____ ID# _____

Reason for today's visit: Routine skin check New Concern: _____

Body site(s) involved: _____

When did it begin? _____

What symptoms are associated? None Bleeding Scabbing Crusting Never seems to heal

Tenderness Irritation Other: _____

Was this ever treated before? No Yes: Surgery Freezing/Burning Medication: _____

Please list your current medications: _____

Do you take aspirin, Plavix, or Coumadin/warfarin? Yes No

Do you have any allergies to medications? Yes No Pharmacy Name / Phone: _____

If yes, list medication and reaction type: _____

Please check appropriate NEW medical conditions since your last visit:

Please check here if there has been no change in medical history since last visit

General

- Unexplained fever
 Unexplained weight change
 Night sweats
 Anorexia
 Other:

Skin

- Abnormal scarring
 Poor wound healing
 Sensitive skin
 Cold sores/fever blisters
 Other:

Infectious Disease

- HIV/AIDS
 Tuberculosis
 Hepatitis B
 Hepatitis C
 Other:

Cardiac

- PACEMAKER
 DEFIBRILLATOR
 Bypass surgery
 High blood pressure
 Heart murmur
 Chest pain
 Other:

Pulmonary

- Shortness of breath
 Cough
 Asthma
 Other:

Endocrine

- Diabetes
 Thyroid disease
 Other:

Gastrointestinal

- Nausea/vomiting/diarrhea
 Colon polyp or cancer
 Irritable bowel disease
 Other:

Renal/Urology

- Dialysis
 Prostate disease
 Other:

Orthopedic

- Artificial joint
 Prosthesis
 Other:

Hematologic:

- Bleeding disorder
 Easy bruising
 Blood clots
 Other:

Immune system

- Organ transplant
Type: _____
 Previous or current cancer
Type: _____
 Current or past chemotherapy
 Other:

Neurologic

- Stroke
 Dizziness
 Weakness or arms/legs
 Decreased sensation
 Other:

Ob/gyn

- Currently pregnant
 Trying to conceive
 Hysterectomy
 Frequent yeast infections
 Other:

Please list any other NEW medical conditions: _____

Please list any surgeries since last visit: _____

Skin Cancer Detection and Prevention:

Do you take sun protective measures? No Yes: Sunscreen Sunglasses Hat Avoiding midday sun

How often do you monitor your skin for sun damage/cancer? Not regularly Monthly self check Routine check-up w/ Dr.

Have you previously used a tanning booth? Yes No Do you currently or periodically use a tanning booth? Yes No

Occupation: _____ Hobbies: _____

Do you smoke? Yes No If yes, how many packs per day? _____

Do you drink alcohol? Yes No If yes, how many drinks per week? _____

This form was completed by: Patient Family or friend Medical Staff _____
Initials

Patient accompanied by: Spouse Other family member: Parent Friend

I hereby acknowledge that the completed information is accurate.

Signature of Patient: _____

Date: _____

Reviewed by: _____

Date: _____