MEDICAL HISTORY FORM

Today's date:	MD:

PATIENT INFORMATION

Last name:	First:	Middle:	Birth date: / /	Gender: M ☐ F ☐

Primary Language: ☐ English ☐ Arabic ☐ French ☐ German ☐ Mandarin ☐ Spanish ☐ Russian ☐ Other

Race: ☐ American Indian ☐ Asian ☐ African American or Black ☐ Native Hawaiian/Other Pacific ☐ White ☐ Unknown ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Primary Pharmacy: Phone:

Address:

REASON FOR TODAY'S VISIT

Concern:	Location:	Duration:	Prior Treatments:
Concern:	Location:	Duration:	Prior Treatments:
Concern:	Location:	Duration:	Prior Treatments:

PAST MEDICAL HISTORY

Adhesive tape allergy	☐ Yes	☐ No	Abnormal scars	☐ Yes	☐ No
Latex allergy	☐ Yes	☐ No	Poor wound healing	☐ Yes	☐ No
Local anesthetics allergy	☐ Yes	☐ No	HSV / cold sore	☐ Yes	☐ No
Epinephrine sensitivity	☐ Yes	☐ No	Eczema	☐ Yes	☐ No
Bacitracin allergy	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Neosporin allergy	☐ Yes	☐ No	Hay fever	☐ Yes	☐ No
Anticoagulant treatment	☐ Yes	☐ No	Heart disease	☐ Yes	☐ No
Bleeding disorders	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Artificial joint	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No
Artificial heart valves	☐ Yes	☐ No	Thyroid disease	☐ Yes	☐ No
Pacemaker / defibrillator	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Mitral valve prolapsed	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Immunosuppressed	☐ Yes	☐ No	Psoriasis	☐ Yes	☐ No
Organ transplant	☐ Yes	☐ No			
CLL Chronic leukemia	☐ Yes	☐ No			
Pre-op/pre-dental antibiotics	☐ Yes	☐ No			
Memory problems	☐ Yes	☐ No			
Fainting / syncope	☐ Yes	☐ No			
Hepatitis	☐ Yes	☐ No			
HIV positive	☐ Yes	☐ No			
MRSA	☐ Yes	☐ No			

MELANOMA HISTORY	
Do you have a history of melanoma?	□ Yes □ No
Do you have a history of other skin cancer(s)?	□ Yes □ No

CURRENT MEDICATIONS			
Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:

MEDICATION ALLERGIES	
Do you have any medication allergies:	□ Yes □ No
List allergies:	
Type of reaction:	

FOR WOMEN ONLY	
Are you pregnant?	□ Yes □ No
Are you breastfeeding?	□ Yes □ No
Are you on birth control?	□ Yes □ No
Do you have regular menstrual cycles?	□ Yes □ No

FAMILY HISTORY OF MELANOMA	
Do you have a family history of melanoma?	□ Yes □ No
Do you have a family history of other skin cancer(s)?	□ Yes □ No
Types:	

SOCIAL HISTORY	
Occupation:	
Do you use tobacco?	□ Yes □ No
Alcohol consumption?	□ Socially □ Moderate □ Heavy
Do you use sunscreen?	□ None □ Daily □ Occasionally
Tanning bed use?	□ None □ Current □ Previous
Do you have any other medical problems or conditions?	

ADDITIONAL SYMPTOMS

Fever	□ Yes	□ No	Shortness of breath	□ Yes	□ No	Swollen lymph nodes	□ Yes	□ No
Chills	□ Yes	□ No	Nausea / vomiting	□ Yes	□ No			
Fatigue	□ Yes	□ No	Abdominal pain	□ Yes	□ No	Joint pain	□ Yes	□ No
Unintentional weight loss	□ Yes	□ No	Diarrhea	□ Yes	□ No	Rash / itch	□ Yes	□ No
			Constipation	□ Yes	□ No	Headache	□ Yes	□ No
Eye Irritation	□ Yes	□ No	Easy bruising	□ Yes	□ No	Anxiety	□ Yes	□ No
Chronic cough	□ Yes	□ No	Blood clots	□ Yes	□ No	Depression	□ Yes	□ No