CENTER FOR Dermatology & Plastic Surgery

MEDICAL HISTORY

Today's Date: _____

Name: _____ DOB: _____

Primary Care Physician / Contact: _____

Referring Physician (if different): _____

Birth Sex: ☐ Male ☐ Female Preferred gender: ☐ Male ☐ Female ☐ Other: _____

Preferred language: _____ Race/Ethnicity: _____

Preferred pharmacy (please include name, address, cross streets or phone number):

_____

How did you hear about us? (PCP, Friend, Insurance, Other): _____

Reason for visit (*separate visit may be required):

☐ Acne ☐ Upper body skin exam ☐ *Hair Loss
☐ Psoriasis ☐ Total body skin exam ☐ *Cosmetic Concerns
☐ Spot(s) of concern ☐ *Rash
☐ Other: _____

Skin Disease History: ☐ **NONE**

☐ Acne ☐ Actinic keratoses (pre-cancers) ☐ Blistering sunburns
☐ Eczema ☐ Basal cell carcinoma ☐ Seborrheic dermatitis
☐ Psoriasis ☐ Squamous cell carcinoma ☐ Atypical/dysplastic moles
☐ Psoriatic Arthritis ☐ Melanoma
☐ Allergic contact dermatitis (Cause?): _____
☐ Other: _____

Do you wear sunscreen? ☐ Yes ☐ No SPF? _____

Have you ever used a tanning bed? ☐ Yes ☐ No
Currently? ☐ Yes ☐ No
Total number of lifetime tanning sessions: _____

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MEDICAL HISTORY

Past Medical History: ☐ **NONE**

☐ Atrial Fibrillation
☐ Coronary Artery or Heart Disease
☐ Heart attack or stents
☐ High Blood Pressure
☐ High Cholesterol
☐ Asthma
☐ COPD
☐ Diabetes
☐ End Stage Renal Disease
☐ GERD (reflux / heart burn)
☐ Anxiety
☐ Depression
☐ Bone Marrow Transplantation
☐ Leukemia
☐ Lymphoma
☐ Glaucoma
☐ Hearing Loss
☐ Herpes or Cold Sores
☐ HIV/AIDS
☐ Seizures
☐ Stroke
☐ Anemia
☐ Thyroid problems (hyper or hypothyroidism)
☐ Arthritis (joint pain): Type: _____
☐ Hepatitis: Type: _____ Treatment: _____
☐ History of Tuberculosis
☐ Solid Organ Transplantation: Organ: _____ Year: _____
☐ Immunosuppression: _____
☐ Cancer (other than skin): Type: _____ Year: _____
☐ Lupus or other autoimmune disease: Type: _____

Past Surgical History: ☐ **NONE**

☐ Skin Cancer Surgery: _____
☐ Cosmetic Procedures: _____
☐ Joint Replacement: Joint: _____ Year: _____
Do you take antibiotics before going to the dentist? ☐ Yes ☐ No
☐ Cancer Surgery (other than skin): _____
☐ Heart Surgery (including pacemaker or other implant): _____
☐ Heart Valve Replacement: Valve: _____ Type: _____ Year: _____
☐ Lung/Abdomen Surgery: _____
☐ Other: _____

Family History (indicate relative & disease): ☐ **NONE**

☐ Melanoma: _____
☐ Skin cancer (non-melanoma): _____
☐ Psoriasis: _____
☐ Other skin disease:_____
☐ Other serious family illnesses: _____

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MEDICAL HISTORY

Social History:

Occupation: _____ Are you married? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No

Do you think of yourself as: ☐ Heterosexual ☐ Lesbian/Gay ☐ Bisexual

☐ Decline to Answer ☐ Other:_____

Do you currently use contraception? ☐ Yes ☐ No If yes, type? _____

Women: Currently pregnant or trying? ☐ Yes ☐ No Currently breastfeeding? ☐ Yes ☐ No

Medications: Please list **each medication** (including over the counter and supplements) with **the dosage**. You may attach a pre-printed list if you prefer. ☐ **NONE**

_____

_____

_____

_____

_____

_____

Allergies: ☐ **NONE**

Medication Allergies: Please list **each medication** (including over the counter) and **the reaction.**

_____

_____

Seasonal or Environmental Allergies: ☐ Yes ☐ No If yes, to what? _____

Are you currently experiencing any of the following?

☐ Fever	☐ Bleeding problems	☐ Blood in urine
☐ Chills	☐ Easy Bruising	☐ Blood in stool
☐ Night Sweats	☐ Joint aches	☐ Nausea / Vomiting
☐ Unintentional weight loss	☐ Sore throat	☐ Abdominal cramps or pain
☐ Headache	☐ Cough	☐ Blurry vision
☐ Weakness	☐ Chest Pain: Severity? _____	
☐ Numbness	☐ Shortness of breath: Severity?_____	

_____

Signature of Patient or Patient's Legal Guardian