Date_______________ **Chart #**____________

MEDICAL HISTORY FORM

Patient Name: ____
Last First M.I. DOB

Place of Birth: ____
City State Zip Code

Employer: ____________________________________ **Occupation:** ____________________________________

Preferred Pharmacy: ____

Did your physician or another provider recommend that you see us? Yes / No Who? ______________________

Primary Care Provider: __________________________ **City:** ________________ **Phone:** _________________

What is the main problem we are seeing you for today? ____

What areas of your body are affected? ____

How long have you had this problem? ____

Please circle all your symptoms: pain, itch, bleeding, enlargement, spreading, burning, redness, embarrassment, blistering, other: ____

What oral medications have you been given for this problem? ____

What topical medications (creams or ointments) have you tried for this problem? __________________________

List any other treatments you have used: ____

Which of these products have been helpful? ____

Current Medications/Supplements: (Dosage and Frequency)

____

____

____

____

Allergies: (Medication Allergies)

____

____

Surgical History:

____

____

____

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Select The Following Medical Conditions That You Currently Have or Have Had (Mark All That Apply)

__Anxiety __Diabetes __Leukemia
__Arthritis __End Stage Renal Disease __Lung Cancer
__Asthma __Esophageal Reflux __Lymphoma
__Atrial Fibrillation __Hearing Loss __Prostate Cancer
__Bone Marrow Transplant __Hepatitis __Radiation Treatment
__Breast Cancer __High Blood Pressure __Seizures
__Colon Cancer __HIV/AIDS __Stroke
__COPD __High Cholesterol __Transplant
__Coronary Artery Disease __Hyperthyroidism
__Other:______________________________________
__Depression __Hypothyroidism ______________________________________

Select Any Of The Following Skin Conditions That You Have Had (Mark All That Apply)

__Acne __Dry Skin __Poison Ivy
__Actinic Keratoses (Precancers) __Eczema __Precancerous Moles
__Asthma __Flaking or Itchy Scalp __Psoriasis
__Basal Cell Carcinoma __Hay Fever/Allergies __Squamous Cell Carcinoma
__Blistering Sunburns __Melanoma __Other:______________________________________

Select Any Of The Following That You Have (Mark All That Apply)

__Allergy to Adhesive __Artificial Heart Valve __MRSA
__Allergy to Lidocaine __Artificial Joint __Premedication Prior to Procedures
__Allergy to Topical Antibiotic Ointment __Blood Thinners __Rapid HB with Epinephrine
__Defibrillator __Pacemaker __Pregnant __Planning Pregnancy __Breastfeeding

Do you wear sunscreen? YES NO If yes, what SPF?________ Do you tan in a tanning salon? YES NO

Do you have a family history of Melanoma? YES NO If yes, which relative?______________________________

Do you have a family history of Basal Cell Carcinoma or Squamous Cell Carcinoma? YES NO
If yes, which relative?______________________________

Are You Currently Or Have You Recently Experienced Any Of The Following (Mark All That Apply)

__Diarrhea __Fatigue ___Unintentional Weight Loss ___Pain/Burning on Urination __Nausea ___Night Sweats

__Weight gain __New Onset of Joint Aches __Vomiting __Cough __Depression __Numbness/Weakness

__Fever or Chills ___Shortness of Breath ___Anxiety

Alcohol Use: None Less Than 1 Drink/Day 1-2 Drinks/Day 3 or More Drinks/Day

Smoking Status: Current Everyday Smoker Current Occasional Smoker Former Smoker Never Smoke

______________________________________ ______________________________
Patient or Patient Representative Signature **Date**

______________________________________ ______________________________
Health Care Provider Signature **Date**

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