Print Form

MEDICAL HISTORY

Patient Name_____**Date**_____
Last **First** **Middle**

Age____**Sex** □ **M** □ **F** **Referred by** □ **Self/Friend** □ **Dr.** _____

Reason for & Location of today's problem_____
How long has the problem been present?_____

Was there any previous treatment? □ **Yes** □ **No** **When?** _____**Type?**_____

Was a biopsy done? □ **No** □ **Yes** □ **Biopsy done by referring Dr.** □ **Other**_____

ALLERGIES □ **None** □ **List**_____

MEDICATIONS □ **None** □ **Aspirin, last taken**_____ □ **blood thinners, last taken**_____

LIST ALL MEDICATIONS, Vitamins, & Herbal supplements_____
_____
_____

SYSTEM REVIEW: Check all that apply regarding your health and add any other important problems.

SKIN
□ abnormal scarring
□ poor healing
□ other skin disorders___
_____

KIDNEY
□ normal
□ dialysis
□ other kidney problems
_____

CONSTITUTIONAL SYMPTOMS
□ none
□ weight loss
□ fever
□ other

EYES/EARS/NOSE/THROAT
□ normal
□ glaucoma
□ hearing aid
□ plastic surgery

RESPIRATORY
□ normal
□ asthma
□ emphysema
□ other lung problem(s)____
_____

GASTROINTESTINAL
□ normal
□ stomach ulcer
□ colitis
□ other GI problems_
_____

MUSCULOSKELETAL
□ normal
□ arthritis
□ artificial joint
□ other_____
_____

NEUROLOGICAL
□ normal
□ stroke
□ seizures
□ other_____
_____

HEMATOLOGIC/LYMPHATIC
□ normal
□ anemia
□ bleeding problems
□ enlarged lymph nodes
□ transfusion

□ pregnant

ENDOCRINE
□ normal
□ diabetes
□ thyroid
□ other_____
_____
_____

CARDIOVASCULAR
□ normal
□ chest pain
□ artificial heart valve
□ pacemaker
□ high blood pressure
□ mitral valve prolapse
□ heart attack (when?) _____
□ other_____

INFECTIONS
□ none
□ hepatitis
□ HIV/AIDS
□ tuberculosis (T.B.)

□ transplant
□ other_____
_____

PAST HISTORY
Previous skin cancer □ **none** □ **list:**_____
Location and date_____
Major illnesses or surgeries □ **none** □ **list:**_____
_____

FAMILY HISTORY
Skin cancer □ **none** □ **melanoma** □ **basal cell** □ **squamous cell** □ **other, list:**_____

SOCIAL HISTORY
Occupation_____**Marital status:** □ **S** □ **M** □ **D** □ **W**
Spouse name_____**Previous sunlight exposure or sunburns:** □ **mild** □ **moderate** □ **extensive**
Do you wear: □ **dentures** □ **glasses** □ **contact lenses** **Smoker:** □ **no** □ **yes, packs/day**_____ □ **former**
Alcohol: □ **no** □ **yes** # **of drinks per week**_____ **Alcohol or drug problems/addictions:** □ **no** □ **describe**_____