PATIENT MEDICAL HISTORY

Patient Name:____Date:________________________

Allergies:____

Skin Conditions	**Yes**	**No**
Have you ever had skin cancer?	□	□
Melanoma?	□	□
Basal Cell Carcinoma?	□	□
Squamous Cell Carcinoma?	□	□
Who treated you?__________________		
Have you had abnormal/dysplastic moles?	□	□
Have you had pre-cancerous Actinic Keratoses?	□	□

List any other skin conditions you have:
(Examples: Eczema, Psoriasis, Acne, Rosacea, Vitiligo)

____

	Yes	No
Do you use sunscreen? SPF#______	□	□
Do you use tanning beds?	□	□
Do you heal with thick (keloid) scars?	□	□
Do you bleed/bruise easily?	□	□
Do you react to bandages or adhesive?	□	□
Do you need antibiotics for the dentist?	□	□
Do you work outdoors?	□	□

Social History	**Yes**	**No**
Tobacco Use?	□	□

□Current every day smoker □Former every day smoker
□Never
Date Started/Quit___________
Have you ever tested positive for TB?

	Yes	No
Alcohol Use?	□	□

□None □Less than 1 drink/day □1-2 drinks daily
□3 or more drinks daily
How many times in the past year have you had 5 or more alcoholic drinks in a day for men, or 4 or more drinks in a day for women?
Please provide the approximate number here:________________

	Yes	No
Do you have a history of drug/alcohol dependency?	□	□

ROS: Circle any *Symptoms* you currently have:

General	weight loss fatigue
Immune	fever night sweats frequent infections
Eye	dryness blurry vision irritation
Heart	chest pain ankle swelling palpitations
Lungs	shortness of breath cough
GI	nausea vomiting diarrhea
Joint	stiffness pain cramping
Neuro	numbness tingling headaches weakness
Endocrine	heat/cold intolerance excessive thirst
Psych	depression anxiety
Heme	easy bleeding bruising swollen nodes
Skin	itch burning redness discoloration scale

Past Surgeries:	**Yes**	**No**
Pacemaker/Defibrillator	□	□
Joint replacement-Site:______	□	□
Heart valve replacement	□	□
Organ transplant-Type:______	□	□
Tubal ligation	□	□

List other surgeries____________________

FAMILY Medical Problems	**Yes**	**No**
Skin cancer	□	□
Melanoma?	□	□
Basal Cell Carcinoma?	□	□
Squamous Cell Carcinoma?	□	□
Abnormal moles	□	□
Eczema	□	□
Asthma	□	□
Seasonal Allergies	□	□
Psoriasis	□	□
Autoimmune diseases	□	□

(Lupus, Rheumatoid arthritis, MS, Crohn's, Colitis, Thyroid)

PMH: Circle you Medical Problems

Cancer	breast prostate colon __________
Immune	HIV Immune deficiency
Eye	Glaucoma Cataract Rosacea
Nose	Seasonal allergies chronic rhinitis
Heart	high blood pressure heart attack high cholesterol atrial fibrillation heart valve problems clotting disorder
Lung	COPD asthma Tuberculosis
GI	acid reflux colitis irritable bowel Hepatitis B or C
Joint	arthritis joint replacement
Brain	stroke seizures migraine headaches
Endocrine	thyroid diabetes polycystic ovary
Psych	depression anxiety attention deficit
Renal	kidney disease

FEMALES: □pregnant □nursing
□Irregular periods
□Planning pregnancy soon
□Birth control pills