



Medical History



Medical History

Name: _____ Date of Birth: ____-____-____ Today's Date: ____-____-____

Who referred you? _____ Family Doctor: _____

What type of work do you do? (if retired, what did you do?) _____

Do you have any allergies to medications? Yes No If Yes, please list medication and reaction below.

MEDICATION

REACTION

_____ hives/rash/itching swelling shortness of breath other: _____

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I have more allergies than I can list above

Review of Systems:

Do you currently have or recently had: Y N New, changing or worrisome skin spot(s)
Y N Allergy or sensitivity to latex→ what reaction? _____
Y N Intolerance or allergy to dental anesthesia or other numbing medications

Medical History: Have you had, or do you have, any of the following?

Y N Arthritis Y N Hepatitis: B C Y N MRSA or VRE infection
Y N Autoimmune disease→ type: _____ Y N HIV/AIDS Y N Organ Transplant
Y N Basal cell carcinoma Y N Melanoma ↓ Y N Radiation treatment
Y N Biopsy of an abnormal mole lymph nodes were: Y N Squamous cell carcinoma
Y N Cancer→ type: _____ positive negative
 not checked unknown

Do you take any blood thinners: Yes No

If yes, which one(s)? Aspirin (including baby aspirin) Coumadin (warfarin) Plavix Aggrenox
 NSAIDs (Advil, Ibuprofen, Naproxen, etc) Other: _____

Have you ever had a blistering sunburn? Yes No

When you are exposed to the sun, does your skin (choose one):

- Always burn, never tan (SPT-1) Usually burn, tan lightly (SPT-2)
- Tan well, burn sometimes (SPT-3) Tan darkly, never burn (SPT-4)

Surgery History:

Do you take antibiotics before teeth cleaning or surgery? Yes No

Have you ever had Mohs surgery for a skin cancer? Yes No

Family History: Has anyone in your immediate family had any of the following? If yes, please list their relationship to you.

My family history is not known to me.

Y N Abnormal moles _____ Y N Eczema _____

Y N Asthma _____ Y N Melanoma _____

Y N Autoimmune disease (lupus rheumatoid arthritis thyroid problems other) _____

Social History:

Do you use sunscreen? Daily When outside for any length of time Often Sometimes Never

Do you visit tanning beds? Yes No

Do you smoke? Yes No If yes, for how long and how much?: _____

Do you drink alcohol? Yes No If yes, how much? _____

(Females Only) Are you pregnant or trying to become pregnant? Yes No Are you breast feeding? Yes No

(Females Only) Are you taking birth control pills or using other methods for birth control? Yes No

If yes, what method(s): birth control pills IUD NuvaRing Depo Provera Other: _____