The Center for Dermatology Medical History Form

Patient Name: _____ DOB: _____ Date: _____

Please list the phone number you prefer to be called with test results: _____

Primary Care Physician: _____ Preferred Pharmacy: _____

Past Medical History

Do you now have, or have you ever been diagnosed with any of the following conditions: (Check if Yes)

- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Atrial fibrillation
- □ Benign Prostate enlargement
- □ Bone Marrow Transplant
- □ Breast Cancer
- □ Colon Cancer
- □ COPD
- □ Coronary artery disease
- □ Depression
- □ Diabetes
- □ End stage kidney disease
- □ GERD/Acid reflux
- □ Hearing loss
- □ Hepatitis B
- □ Hepatitis C
- □ High blood pressure
- □ HIV/AIDS
- □ High cholesterol
- □ Hyperthyroid (high)
- □ Hypothyroid (low)
- □ Leukemia
- □ Lung Cancer
- □ Lymphoma
- □ Prostate cancer (males)
- □ Radiation treatment
- □ Seizures
- □ Stroke
- □ **None of these**

Other medical problems not listed above**:** _____

_____

List any major surgeries: _____

Skin Disease History: Have you ever had skin cancer? □ Yes □ No □ Not Sure
If yes, check what type(s): □ Basal Cell □ Squamous Cell □ Melanoma □ Not sure
Do you use sunscreen? □ Yes □ No Have you ever used a tanning bed? □ Yes □ No
Do any of your blood relatives have melanoma? □ Yes □ No Relationship: _____

Medications:

Current medications: _____

_____

List any medication allergies: _____

Social History: Do you drink alcohol? □ Yes □ No If yes, _____ drinks per day
Do you smoke? □ Yes □ Quit □ No If yes, _____ packs per day,

ROS

Do you have problems with healing? □ Yes □ No or excessive scarring (keloid)? □ Yes □ No
Do you have any problems with your immune system? □ Yes □ No

Alerts

Have you ever had a bad reaction to local anesthesia? □ Yes □ No
Are you allergic to adhesive? □ Yes □ No
Are you allergic to topical antibiotic ointments? □ Yes □ No
Do you have an artificial heart valve? □ Yes □ No
Are you on blood thinners? □ Yes □ No
Do you have a defibrillator? □ Yes □ No
Do you have a pacemaker? □ Yes □No
Have you been told to take antibiotics prior to dental or surgical procedures? □ Yes □ No
Do you get a rapid heartbeat with epinephrine? □ Yes □ No
Are you pregnant or planning pregnancy? □ Yes □ No If pregnant, due date: _____