MEDICAL HISTORY FORM

Today's date:	Primary Care Physician:

PATIENT INFORMATION

Last name:	First:	Middle:	Birth date: / /

Marital Status:

Primary Language: □ English □ Arabic □ French □ German □ Mandarin □ Spanish □ Russian □ Other

Race: □ American Indian □ Asian □ African American or Black □ Native Hawaiian/Other Pacific □ White □ Unknown □ Other

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Primary Pharmacy: Address:

REASON FOR TODAY'S VISIT

Concern:	Location:	Duration:	Prior Treatments:
Concern:	Location:	Duration:	Prior Treatments:
Concern:	Location:	Duration:	Prior Treatments:

PAST MEDICAL HISTORY

Adhesive tape allergy	□ Yes □ No	Abnormal scars	□ Yes □ No
Latex allergy	□ Yes □ No	Poor wound healing	□ Yes □ No
Local anesthetics allergy	□ Yes □ No	HSV / cold sore	□ Yes □ No
Epinephrine sensitivity	□ Yes □ No	Eczema	□ Yes □ No
Bacitracin allergy	□ Yes □ No	Asthma	□ Yes □ No
Neosporin allergy	□ Yes □ No	Hay fever	□ Yes □ No
Anticoagulant treatment	□ Yes □ No	Heart disease	□ Yes □ No
Bleeding disorders	□ Yes □ No	Diabetes	□ Yes □ No
Artificial joint	□ Yes □ No	Kidney disease	□ Yes □ No
Artificial heart valves	□ Yes □ No	Thyroid disease	□ Yes □ No
Pacemaker / defibrillator	□ Yes □ No	Lupus	□ Yes □ No
Mitral valve prolapse	□ Yes □ No	Arthritis	□ Yes □ No
Immunosuppressed	□ Yes □ No	Psoriasis	□ Yes □ No
Organ transplant	□ Yes □ No	Memory problems	□ Yes □ No
CLL Chronic leukemia	□ Yes □ No	Fainting / syncope	□ Yes □ No
Pre-op/pre-dental antibiotics	□ Yes □ No	HIV positive	□ Yes □ No
Hepatitis	□ Yes □ No	MRSA	□ Yes □ No

MELANOMA HISTORY	
Do you have a history of melanoma?	□ Yes □ No
Do you have a history of other skin cancer(s)?	□ Yes □ No

CURRENT MEDICATIONS			
Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:

MEDICATION ALLERGIES	
Do you have any medication allergies:	□ Yes □ No
List allergies:	

FOR WOMEN ONLY	
Are you pregnant?	□ Yes □ No
Are you breastfeeding?	□ Yes □ No
Are you on birth control?	□ Yes □ No
Do you have regular menstrual cycles?	□ Yes □ No

FAMILY HISTORY OF MELANOMA	
Do you have a family history of melanoma?	□ Yes □ No
Do you have a family history of other skin cancer(s)?	□ Yes □ No
Types:	

SOCIAL HISTORY	
Occupation:	
Do you use tobacco?	□ Yes □ No
Alcohol consumption?	□ Socially □ Moderate □ Heavy
Do you use sunscreen?	□ None □ Daily □ Occasionally
Tanning bed use?	□ None □ Current □ Previous
Do you have any other medical problems or conditions?	

ADDITIONAL SYMPTOMS								
Fever	□ Yes	□ No	Shortness of breath	□ Yes	□ No	Swollen		
Chills	□ Yes	□ No	Nausea / vomiting	□ Yes	□ No	Lymph nodes	□ Yes	□ No
Fatigue	□ Yes	□ No	Abdominal pain	□ Yes	□ No	Joint pain	□ Yes	□ No
Unintentional	□ Yes	□ No	Diarrhea	□ Yes	□ No	Rash / itch	□ Yes	□ No
Weight Loss	□ Yes	□ No	Constipation	□ Yes	□ No	Headache	□ Yes	□ No
Eye Irritation	□ Yes	□ No	Easy bruising	□ Yes	□ No	Anxiety	□ Yes	□ No
Chronic cough	□ Yes	□ No	Blood clots	□ Yes	□ No	Depression	□ Yes	□ No