Medical History

Patient Name: _____

Please list the reasons for your visit today in each space provided.

Please circle one option for each problem.

1. Growth Rash Acne Other_____
Location of problem: _____
Duration: _____
Symptom: Painful ❑ Itchy ❑ Other_____
Previous treatment tried: _____
Effect of treatment: _____

2. Growth Rash Acne Other_____
Location of problem: _____
Duration: _____
Symptom: Painful ❑ Itchy ❑ Other_____
Previous treatment tried: _____
Effect of treatment: _____

3. Growth Rash Acne Other_____
Location of problem: _____
Duration: _____
Symptom: Painful ❑ Itchy ❑ Other_____
Previous treatment tried: _____
Effect of treatment: _____

4. Growth Rash Acne Other_____
Location of problem: _____
Duration: _____
Symptom: Painful ❑ Itchy ❑ Other_____
Previous treatment tried: _____
Effect of treatment: _____

Daily Prescription Medication: ❑ None ❑ Yes, please list_____

Any allergies to Medication: ❑ None ❑ Yes, please list_____

Please FILL in the bubbles for the following:

Fever	○ Y	○ N	**Seizures**	○ Y	○ N	**Thyroid Disease**	○ Y	○ N
Chills	○ Y	○ N	**Kidney Disorder**	○ Y	○ N	**Diabetes**	○ Y	○ N
Weight Loss	○ Y	○ N	**Bleeding Disorder**	○ Y	○ N	**Dysplastic Nevus**	○ Y	○ N
Diarrhea	○ Y	○ N	**Heart Abnormality**	○ Y	○ N	**Asthma**	○ Y	○ N
Stomach Ulcer	○ Y	○ N	**Depression/Psychosis**	○ Y	○ N	**Eczema**	○ Y	○ N
Migraine	○ Y	○ N	**High Blood Pressure**	○ Y	○ N	**Hay Fever/Allergies**	○ Y	○ N

List any other significant medical issues / surgical procedures not listed above? _____
OCCUPATION: _____

Melanoma ○ Y ○ N When: _____ **Other type of Cancer** ○ Y ○ N When: _____
Skin Cancer (BCC/SCC) ○ Y ○ N When: _____ **If Yes, Radiation or Chemotherapy?** ○ Y ○ N

Tanning Parlor use: ○ Active ○ Past ○ Never
Smoking: ○ Active ○ Past ○ Never
Alcohol Consumption: ○ Active ○ Past ○ Never

For women only: Are you pregnant or trying to get pregnant? Yes ❑ No ❑ Due Date: __/___/___

Family History: Please list any patients that you are related to:_____
Asthma, Hay Fever, Eczema ❑ Who: _____ **Abnormal moles** ❑ Who: _____
Melanoma ❑ Who:_____ **Other Skin Cancer** (BCC or SCC) ❑ Who: _____
Other type of Cancer ○ Y ○ N Who: _____