the DERMATOLOGY GROUP P.A

Medical History Form

Patient Name: _____ **Date:** _____ **MRN:** _____
(For Office Use Only)

PATIENT DEMOGRAPHICS

Date of Birth: _____ **Gender:** ☐ Male ☐ Female **Preferred Language:** _____

Race (Please check one):

- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other Race

Ethnic Group (Please check one):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

PAST MEDICAL HISTORY (Please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ BPH (Enlarged Prostate)
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD (Chronic Lung Disease)
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Acid Reflux)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ None

☐ Other: _____

PAST SURGICAL HISTORY (Please check all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy ☐ Right ☐ Left
- ☐ Lumpectomy ☐ Right ☐ Left
- ☐ Breast Biopsy
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA (Angioplasty)
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Knee Replacement ☐ Right ☐ Left
- ☐ Hip Replacement ☐ Right ☐ Left
- ☐ Kidney Biopsy
- ☐ Kidney Removed ☐ Right ☐ Left
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP (Prostate Surgery)
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed ☐ Right ☐ Left
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ None

☐ Other: _____

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SKIN DISEASE HISTORY (Please check all that apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ None

☐ Other: _____

Do you wear Sunscreen? ☐ Yes ☐ No If yes, what SPF? _____

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No

If yes, which relative(s)? _____

Any other family history: _____

PHARMACY & MEDICATIONS (Please enter all current medications, dosage and frequency)

Pharmacy Name: _____ Phone #: _____ Address: _____

Medication / Dosage / Frequency	Medication / Dosage / Frequency

☐ None

ALLERGIES (Please enter all allergies)

☐ None

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SOCIAL HISTORY (Please check all that apply)

Alcohol Use:

- ☐ None
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

Cigarette Smoking:

- ☐ Never smoked
- ☐ Quit: Former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily

REVIEW OF SYSTEMS: Are you currently experiencing any of the following? (Please check all that apply)

- ☐ Allergy to Adhesive
- ☐ Blood Thinners
- ☐ Pregnancy or Planning a Pregnancy
- ☐ Swollen Lymph Nodes
- ☐ Problems with Bleeding
- ☐ Problems with Healing
- ☐ Problems with Scarring (Hypertrophic or Keloid)
- ☐ Rash
- ☐ Immunosuppression
- ☐ Hay Fever
- ☐ Chest Pain
- ☐ Fever or Chills
- ☐ Night Sweats
- ☐ Unintentional Weight Loss
- ☐ Thyroid Problems
- ☐ Sore Throat
- ☐ Blurry Vision
- ☐ Abdominal Pain
- ☐ Bloody Stool
- ☐ Bloody Urine
- ☐ Arthritis
- ☐ Muscle Weakness
- ☐ Neck Stiffness
- ☐ Headaches
- ☐ Seizures
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Anxiety
- ☐ Depression

☐ Other Symptoms: _____

☐ None

ALERTS: Are you currently experiencing any of the following? (Please check all that apply)

- ☐ Allergy to Lidocaine
- ☐ Allergy to topical Antibiotic Ointment
- ☐ Artificial Heart Valve
- ☐ Defibrillator
- ☐ Pacemaker
- ☐ Premedication prior to procedure
- ☐ Rapid Heartbeat with Epinephrine

☐ Other: _____

☐ None