MEDICAL HISTORY FORM

Today's date:	MD:

PATIENT INFORMATION

Last name:	First:	Middle:	Birth date:

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:
Concern:	Location:	Duration:	Prior Treatments:

PAST MEDICAL HISTORY

Adhesive tape allergy ☐ Yes ☐ No
Latex allergy ☐ Yes ☐ No
Local anesthetics allergy ☐ Yes ☐ No
Epinephrine sensitivity ☐ Yes ☐ No
Bacitracin allergy ☐ Yes ☐ No
Neosporin allergy ☐ Yes ☐ No
Anticoagulant treatment ☐ Yes ☐ No
Bleeding disorders ☐ Yes ☐ No
Artificial joint ☐ Yes ☐ No
Artificial heart valves ☐ Yes ☐ No
Pacemaker / defibrillator ☐ Yes ☐ No
Mitral valve prolapsed ☐ Yes ☐ No
Immunosuppressed ☐ Yes ☐ No
Organ transplant ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Pre-op/pre-dental antibiotics ☐ Yes ☐ No
Memory problems ☐ Yes ☐ No
Fainting / syncope ☐ Yes ☐ No
Hepatitis or liver disease ☐ Yes ☐ No
HIV positive ☐ Yes ☐ No
MRSA ☐ Yes ☐ No
Prior Hospitalizations & Surgery ☐ Yes ☐ No
Dates:___________________________________

Abnormal scars ☐ Yes ☐ No
Poor wound healing ☐ Yes ☐ No
HSV / cold sore ☐ Yes ☐ No
Eczema ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Hay fever ☐ Yes ☐ No
Heart disease ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Kidney disease ☐ Yes ☐ No
Thyroid disease ☐ Yes ☐ No
Lupus ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No
Psoriasis ☐ Yes ☐ No
High blood pressure ☐ Yes ☐ No
Seizure / Epilepsy ☐ Yes ☐ No
Stomach Ulcer/Intestinal ☐ Yes ☐ No
Glaucoma/eye disease ☐ Yes ☐ No
Tuberculosis/Lung Dz ☐ Yes ☐ No
Venereal disease ☐ Yes ☐ No
Hives ☐ Yes ☐ No
Mole change color/shape/size ☐ Yes ☐ No
Other ______________

MELANOMA HISTORY

Do you have a history of melanoma?	☐ Yes ☐ No	Date:_________ Location:_____________
Do you have a history of other skin cancer(s)?	☐ Yes ☐ No Type:_____________	Date:_________Location:______________

CURRENT MEDICATIONS			
INCLUDING BIRTH CONTROL, OVER THE COUNTER (OTC) OR HERBAL MEDICATIONS			
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
Currently trying to conceive or planning a pregnancy?	◻ Yes ◻ No
Are you breastfeeding?	◻ Yes ◻ No
Are you on birth control?	◻ Yes ◻ No
Do you have regular menstrual cycles?	◻ Yes ◻ No
Do you experience vaginal yeast infections?	◻ Yes ◻ No
Please inform the doctor at any time if you plan to, or become pregnant during your treatment period.	

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

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

INTEREST IN COSMETIC PROCEDURES?			
Botox	◻ Yes ◻ No	Blood vessel/spider vein destruction	◻ Yes ◻ No
Fillers	◻ Yes ◻ No	Skin tag removal	◻ Yes ◻ No
Wrinkle Therapy	◻ Yes ◻ No	Chemical peels	◻ Yes ◻ No