



PAST MEDICAL HISTORY

Please complete the following medical history form to help evaluate your present, past and future health concerns.

NAME _____ DATE _____

AGE _____ SEX F M REFERRED BY Self Dr. _____

Reason(s) for today's visit _____

Skin areas involved _____

How long has the problem been present? _____

Previous treatment? No Yes list: _____

Allergies to Medicines: No Yes list: _____

Medications currently taking (include Vitamins / Over -The-Counter / Herbal): _____

SYSTEM REVIEW: Please review each section and check normal if no abnormalities

Skin <input type="checkbox"/> normal <input type="checkbox"/> abnormal scarring <input type="checkbox"/> poor healing <input type="checkbox"/> other skin disorders: _____	Hematologic/Lymphatic <input type="checkbox"/> normal <input type="checkbox"/> anemia <input type="checkbox"/> bleeding problems <input type="checkbox"/> enlarged lymph nodes	Constitutional Symptoms <input type="checkbox"/> none <input type="checkbox"/> weight loss <input type="checkbox"/> fever <input type="checkbox"/> other: _____	Eyes/Ears/Nose/Throat <input type="checkbox"/> normal <input type="checkbox"/> glaucoma <input type="checkbox"/> hearing aid <input type="checkbox"/> plastic surgery
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Cardiovascular <input type="checkbox"/> normal <input type="checkbox"/> leaky heart valve <input type="checkbox"/> abnrm. heart rhythm <input type="checkbox"/> angina <input type="checkbox"/> artificial heart valve <input type="checkbox"/> pacemaker <input type="checkbox"/> hypertension <input type="checkbox"/> heart attack (when?) _____	Respiratory <input type="checkbox"/> normal <input type="checkbox"/> asthma <input type="checkbox"/> emphysema <input type="checkbox"/> other lung problems: _____	Gastrointestinal <input type="checkbox"/> normal <input type="checkbox"/> stomach ulcer <input type="checkbox"/> colitis <input type="checkbox"/> liver damage <input type="checkbox"/> Other GI problem: _____	Musculoskeletal <input type="checkbox"/> normal <input type="checkbox"/> arthritis <input type="checkbox"/> artificial joint whole joint? __ Y __ N <input type="checkbox"/> date of surgery _____ <input type="checkbox"/> other: _____
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Neurological <input type="checkbox"/> normal <input type="checkbox"/> stroke <input type="checkbox"/> seizures <input type="checkbox"/> other _____	Psychiatric <input type="checkbox"/> normal <input type="checkbox"/> depression <input type="checkbox"/> anxiety attacks <input type="checkbox"/> other _____	Endocrine <input type="checkbox"/> normal <input type="checkbox"/> diabetes <input type="checkbox"/> thyroid <input type="checkbox"/> kidney disease	Infections <input type="checkbox"/> none <input type="checkbox"/> other _____ <input type="checkbox"/> hepatitis <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> tuberculosis (T.B.)
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FEMALE PATIENTS : Are you pregnant? No Yes Nursing? No Yes

PAST HISTORY Previous skin cancer: No Yes (year & body site) _____
Major illnesses, surgery, hospitalizations: _____

FAMILY HISTORY Skin Cancer None Melanoma Basal cell Squamous cell
Other skin conditions _____

SOCIAL HISTORY Do you wear: Dentures Glasses Contact lenses
Previous sun exposure or sunburns: Mild Moderate Extensive Tanning bed use
Do you smoke? No Former Yes, packs per day _____
Do you consume Alcohol ? No Social/ occasional
Alcohol or drug problems/addictions: No Yes Describe _____

Reviewed: _____ M.D.