**PATIENT MEDICAL HISTORY**

Today’s date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient:

Date of Birth / / Age: \_\_\_\_\_\_\_\_\_\_ Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Referring Doctor’s Group: City: State:

Medication Allergies: NONE SULFA PENICILLIN □LATEX Other (list):

Medication you are taking (include OTC, herbal, vitamins): NONE Aspirin Coumadin OTHER (List):

Pharmacy: Address: Phone - -

**MAJOR SURGERY:** NONE Appendix Gallbladder Heart Hysterectomy Joint Replacement (year: ) Other (list):

**Do you have now or have you ever had diseases or conditions of: (please circle YES or NO)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Arthritis/Joint Problems | **YES** |  | **NO** | Hearing Loss | **YES** |  | **NO** |
| Artificial Joint | **YES** |  | **NO** | Exposed to HIV/AIDS? | **YES** |  | **NO** |
| Asthma, Hay fever | **YES** |  | **NO** | Heart Disease/Attack | **YES** |  | **NO** |
| Bladder Problems | **YES** |  | **NO** | Heart Murmur | **YES** |  | **NO** |
| Blood Clots | **YES** |  | **NO** | Hepatitis | **YES** |  | **NO** |
| Cancer | **YES** |  | **NO** | High Blood Pressure | **YES** |  | **NO** |
| Cataracts/Glaucoma | **YES** |  | **NO** | Irregular Heartbeat | **YES** |  | **NO** |
| Convulsions/Epilepsy | **YES** |  | **NO** | Kidney Problems | **YES** |  | **NO** |
| Diabetes | **YES** |  | **NO** | Liver/Gall Bladder Disease | **YES** |  | **NO** |
| Eczema | **YES** |  | **NO** | Pacemaker/Defibrillator | **YES** |  | **NO** |
| Emotional Problems | **YES** |  | **NO** | Thyroid Problems | **YES** |  | **NO** |
| GI/Stomach Problems | **YES** |  | **NO** | TB/Lung Problems | **YES** |  | **NO** |
| Cholesterol Problems | **YES** |  | **NO** |  |  |  |  |

Other Medical problems, please list:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SKIN:** |  |  |  | | | |
| Yes□ | No□ | Have you personally had skin cancer? |
| Yes□ | No□ | Have you had a pre-cancer? |
| Yes□ | No□ | Do you have a personal history of any specific skin disease? | Eczema | Psoriasis | Rosacea | Acne |

Other (list):

|  |  |  |
| --- | --- | --- |
| Yes□ | No□ | Do you have problems with skin or wound healing? |
| Yes□ | No□ | Do you develop keloids or thick scars after surgery? |
| Yes□ | No□ | Do you bleed easily? |

**SOCIAL:**

Yes No Do you drink alcohol? Yes No Do you use tobacco products?

**FAMILY HISTORY**: Has anyone in your family had: □ Eczema □ Psoriasis □ Hay Fever □Asthma

Yes No Melanoma (If yes, who?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Other cancer (if yes, who?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast Pancreatic Colon Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHIEF COMPLAINT:** Acne Warts Mole Rash Eczema Growth Other

How long have you had this problem? Where on the body? Are your symptoms: Mild Moderate Severe Is today a Good Day Average Day Bad Day

Briefly describe your symptoms:

Prior Treatments: