PATIENT MEDICAL HISTORY

Patient: _____ Today's date: _____

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: _____

_____