

Patient Medical History

Name: _____ Birth Date: _____ Age: _____ Today's Date: _____

What skin problem(s) are we seeing you for today?

Are you interested in a full body skin exam today (useful for skin cancer screening), or only an exam of problem areas?

Full body exam Problem areas only

PLEASE CIRCLE THE APPROPRIATE ANSWERS

Do you have or have you ever been treated for:

- Duodenal, peptic, or stomach ulcer... **YES...NO**
- Tuberculosis **YES...NO**
- Heart Disease **YES...NO**
- Heart Pacemaker **YES...NO**
- High Blood Pressure **YES...NO**
- Liver Disease or Cirrhosis **YES...NO**
- Hepatitis **YES...NO**
- Diabetes **YES...NO**
- Glaucoma **YES...NO**
- Eczema **YES...NO**
- AIDS **YES...NO**
- HIV Positive **YES...NO**
- Melanoma **YES...NO**
- Other Skin Cancer **YES...NO**
- Cancer (not skin) **YES...NO**

Have you ever had any medical problems not listed above? (Please list) YES...NO

Have you ever been hospitalized or had surgery? (Please list) YES...NO

Are you taking any medicines? YES...NO

Please list all medicines you are currently taking. Include over-the-counter medicines, aspirin, hormones, birth control pills, vitamins, etc. If you brought a written list, just give us a copy.

Are you allergic to any medicines or anesthetics? (If "Yes", please list) YES...NO

Are you allergic to:

- Adhesive Tape..... **YES...NO**
- Iodines **YES...NO**
- Neosporin **YES...NO**

Has any member of your family ever had:

- Asthma, hayfever, hives, sinus problems... **YES...NO**
- Eczema **YES...NO**
- Diabetes **YES...NO**
- Melanoma **YES...NO**
- Other Skin Cancer **YES...NO**

If "YES" to any of the above, please list relationship to person and the problem _____

Do you smoke? YES...NO

Do you drink alcohol? (circle one):

Never Rarely Occasionally Frequently Heavily

Estimate your usual level of sun exposure (circle one)

Minimal Moderate Significant

Do you regularly use:

- Sunscreens..... **YES...NO**
- Hats **YES...NO**

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Are you having any chronic problems with any of the following issues? (circle yes or no)

<i>Constitutional</i>		
Persistent Fever	yes	no
Persistent chills	yes	no
Night sweats	yes	no
Significant weight gain	yes	no
Significant weight loss	yes	no
Significant loss of appetite	yes	no
Significant decrease in energy level	yes	no
<i>ENT</i>		
Sores in the mouth	yes	no
<i>Cardiovascular</i>		
Chest pain	yes	no
<i>Respiratory</i>		
Persistent cough	yes	no
Shortness of breath	yes	no
Coughing up blood	yes	no
<i>Gastrointestinal</i>		
Abdominal pain	yes	no
Nausea	yes	no
Vomiting	yes	no
Diarrhea	yes	no
Constipation	yes	no
Blood in the stools	yes	no
<i>Genitourinary</i>		
Pain or burning on urination	yes	no
Blood in the urine	yes	no

<i>Musculoskeletal</i>		
Arthritis	yes	no
<i>Neurological</i>		
Headache	yes	no
Numbness	yes	no
Weakness	yes	no
<i>Psychiatric</i>		
Depression	yes	no
Anxiety	yes	no
<i>Endocrine</i>		
Feel much hotter than other people	yes	no
Feel much colder than other people	yes	no
(Females only): Are you currently pregnant	yes	no
<i>Hematologic</i>		
Easy bleeding or bruising	yes	no
<i>Allergic/Immunologic</i>		
Hay fever	yes	no
Hives	yes	no
Asthma	yes	no
Sinus Trouble	yes	no
<i>Skin</i>		
New or changing moles	yes	no
Poor wound healing or keloids	yes	no

Explain:
