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:

PAST MEDICAL HISTORY

Adhesive tape allergy	□ Yes	□ No	Abnormal scars	□ Yes	□ No
Anticoagulant treatment	□ Yes	□ No	Arthritis	□ Yes	□ No
Artificial heart valves	□ Yes	□ No	Asthma	□ Yes	□ No
Artificial joint	□ Yes	□ No	Diabetes	□ Yes	□ No
Bacitracin allergy	□ Yes	□ No	Eczema	□ Yes	□ No
Bleeding disorders	□ Yes	□ No	Hay fever	□ Yes	□ No
CLL Chronic leukemia	□ Yes	□ No	Heart disease	□ Yes	□ No
Epinephrine sensitivity	□ Yes	□ No	HSV / cold sore	□ Yes	□ No
Fainting / syncope	□ Yes	□ No	Kidney disease	□ Yes	□ No
Latex allergy	□ Yes	□ No	Lupus	□ Yes	□ No
Local anesthetics allergy	□ Yes	□ No	Poor wound healing	□ Yes	□ No
Memory problems	□ Yes	□ No	Psoriasis	□ Yes	□ No
Mitral valve prolapse	□ Yes	□ No	Thyroid disease	□ Yes	□ No
MRSA	□ Yes	□ No			
Neosporin allergy	□ Yes	□ No			
Organ transplant	□ Yes	□ No			
Pacemaker / defibrillator	□ Yes	□ No			
Pre-op/pre-dental antibiotics	□ Yes	□ No			

PERSONAL HISTORY OF SKIN CANCER

Do **you** have a history of melanoma?	□ Yes	□ No	□ Unknown
Do **you** have a history of other skin cancer(s)?	□ Yes	□ No	□ Unknown

Other skin cancers (Check all that apply):

□ Basal Cell □ Squamous Cell □ Unknown

FAMILY HISTORY OF SKIN CANCER

Does anyone in **your family** have a history of melanoma?	□ Yes: Relationship_____	□ No	□ Unknown
Does anyone in **your family** have history of other skin cancer(s)?	□ Yes: Relationship_____	□ No	□ Unknown

CURRENT MEDICATIONS FROM OTHER DOCTORS			
Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:
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
Are you breastfeeding?	□ Yes □ No
Are you on birth control?	□ Yes □ No
Do you have regular menstrual cycles?	□ Yes □ No

SOCIAL HISTORY	
Occupation:	
Do you use tobacco?	□ Yes □ No
Alcohol consumption?	□ None □ Socially □ Moderate □ Heavy
Do you use sunscreen?	□ None □ Daily □ Occasionally
Tanning bed use?	□ None □ Current □ Previous
Do you have any other medical problems or conditions?	

ADDITIONAL SYMPTOMS

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

Signature: _____ Date: _____ Relationship to Patient: _____