

Dermatology Physicians Group: Patient Medical History Form

Name: _____ Appointment Date: _____

Select any of the following medical conditions you currently have:

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- Bone Marrow Transplant
- BPH
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression

- Diabetes
- End Stage Renal Disease
- GERD
- Hearing Loss
- Hepatitis
- Hypertension
- HIV / AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Leukemia

- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- NONE
- Other

Past Surgical History

Have you had any surgeries on the following organs?

- Appendix (Appendectomy)
- Bladder (Cystectomy)
- Breast: Breast Biopsy
- Breast: Lumpectomy (Right, Left, Bilateral)
- Breast: Mastectomy (Right, Left, Bilateral)
- Colon (Colectomy): Colon Cancer Resection
- Colon (Colectomy): Diverticulitis
- Colon (Colectomy): Inflammatory Bowel Disease
- Colon: Colostomy
- Gallbladder (Cholecystectomy)
- Heart: Coronary Artery Bypass Surgery
- Heart: Heart Transplant
- Heart: Mechanical Valve Replacement
- Heart: PTCA
- Joint Replacement: Hip (Right, Left, Bilateral)
- Joint Replacement: Knee (Right, Left, Bilateral)
- Kidney: Kidney Biopsy
- Kidney: Kidney Stone Removal
- Kidney: Kidney Transplant

- Kidney: Nephrectomy
- Liver: Hepatectomy
- Liver: Liver Transplant
- Live: Shunt
- Ovaries (Oophorectomy): Endometriosis
- Ovaries (Oophorectomy): Ovarian Cancer
- Ovaries (Oophorectomy): Ovarian Cyst
- Ovaries: Tubal Ligation
- Pancreas: Pancreatectomy
- Postate (Prostatectomy): Prostate Biopsy
- Prostate (Prostatectomy): Prostate Cancer
- Prostate (Prostatectomy): TURP
- Rectum: APR
- Rectum: Low Anterior Resection
- Skin: Basal Cell Carcinoma
- Skin: Melanoma
- Skin: Skin Biopsy
- Skin: Squamous Cell Carcinoma

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- Spleen (Splenectomy)
- Testicles (Orchiectomy)
- Uterus (Hysterectomy): Fibroids
- Uterus (Hysterectomy): Uterine Cancer
- Uterus (Hysterectomy): Cervical Cancer

- NONE
- Other

Skin Disease History

Have you had any of the following?

- Actinic Keratoses
- Basal Cell Skin Cancer
- Blistering Sunburns
- Melanoma
- Abnormal Moles
- Squamous Cell Skin Cancer
- NONE
- Other

Do you have a family history of Melanoma?

- Yes No

If yes, which relative?

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Grandson |
| <input type="checkbox"/> Father | <input type="checkbox"/> Granddaughter |
| <input type="checkbox"/> Sister | <input type="checkbox"/> Other |
| <input type="checkbox"/> Brother | |
| <input type="checkbox"/> Daughter | |
| <input type="checkbox"/> Son | |
| <input type="checkbox"/> Uncle | |
| <input type="checkbox"/> Aunt | |
| <input type="checkbox"/> Nephew | |
| <input type="checkbox"/> Niece | |
| <input type="checkbox"/> Grandmother | |
| <input type="checkbox"/> Grandfather | |

Medications

List all current medications:

Allergies

List all allergies and reactions if known:

Social History

Smoking Status (please choose one):

- Current every day smoker
- Current someday smoker
- Former smoker
- Never smoker
- Unknown if ever smoked

Alcohol Intake (please choose one):

- None
- 1 or less per day
- 1-2 per day
- 3 or more per day

Tanning Bed Use:

- Yes No

Do you regularly use Sunscreen:

- Yes No

Occupation:

Family Medical History (Please include only first-degree relatives)

Review of Systems

Please check yes or no for the following:

Symptom	Yes	No
Fever or Chills		
Nausea or Vomiting		
Diarrhea		
Cough		
Excessive Bleeding or Easy Bruising		
Artificial Heart Valve		
Artificial Joints		
Defibrillator or Pacemaker		