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

- [ ] 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?

- [ ] Mother
- [ ] Father
- [ ] Sister
- [ ] Brother
- [ ] Daughter
- [ ] Son
- [ ] Uncle
- [ ] Aunt
- [ ] Nephew
- [ ] Niece
- [ ] Grandmother
- [ ] Grandfather
- [ ] Grandson
- [ ] Granddaughter
- [ ] Other

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

Tanning Bed Use:

☐ **Yes** ☐ **No**

Do you regularly use Sunscreen:

☐ **Yes** ☐ **No**

Alcohol Intake (please choose one):

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

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		