Medical History Form

Patient Name:_____ Date of Birth:_____ Today's Date:_____

Primary Care Physician(Phone #):_____

List all current medications (prescription, over-the-counter, vitamins):_____

_____

List all medication allergies: If yes, what kind of reaction:_____

_____

Medical conditions that you currently have or being treated for:

□Anxiety	□End Stage Renal Disease	□Prostate Cancer
□Arthritis	□GERD/heartburn	□Radiation Treatment
□Asthma	□Hearing Loss	□Seizures
□Atrial Fibrillation (irregular heartbeat)	□Hepatitis	□Stroke
□BPH/Enlarged Prostate	□Hypertension (BP)	□Anemia
□Bone Marrow Transplant	□HIV/AIDS	□Colitis
□Breast Cancer	□Hypercholesterolemia (high chol.)	□Stomach Ulcers
□Colon Cancer	□Hyperthyroidism (High)	□Kidney/bladder disorder
□COPD	□Hypothyroidism (Low)	□Lupus/Autoimmune disorder
□Coronary Artery Disease	□Leukemia	□Glaucoma
□Depression	□Lung Cancer	□Tuberculosis
□Diabetes	□Lymphoma	□Sexually transmitted infections

□Other_____

<u>Surgical History:</u> Please list all surgeries and year.

_____

_____

_____

Have you had any of the following Skin conditions:

□Acne	□Actinic Kerotoses	□Asthma	□Basal Cell Skin Cancer
□Blistering Sunburns	□Dry Skin	□Eczema	□Flaking or Itchy Scalp
□Hay Fever/Allergies	□Melanoma	□Poison Ivy	□Pathology Proven Dysplastic Moles
□Psoriasis	□Squamous Cell Skin Cancer	□Other_____	

Do you wear sunscreen? Y N **If yes, what SPF?**_____ **Do you use a tanning salon?** Y N

Do you have a family history of Melanoma? Y N **If yes, who?**_____

Do (Did) you drink alcohol? Y N **How much?**_____

Do (Did) you use illegal drugs? Y N **What kind(s)?**_____

Smoking Status:

□Current every day smoker □ Current some day smoker □Former smoker □Never smoker