



MEDICAL HISTORY FORM

Patient Name: _____ Date: _____ Date of Birth: _____

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| <p>Do you have or have you ever had any of the following (check all that apply)?</p> <p><input type="checkbox"/> Previous skin cancer / Melanoma If yes, please list locations and dates: _____ _____</p> <p><input type="checkbox"/> Keloids <input type="checkbox"/> Poor wound healing <input type="checkbox"/> Prolonged bleeding / bleeding disorder <input type="checkbox"/> Skin infections <input type="checkbox"/> Blood transfusions <input type="checkbox"/> Infectious hepatitis <input type="checkbox"/> HIV <input type="checkbox"/> Leukemia / lymphoma <input type="checkbox"/> Other cancer If yes, please list and indicate whether in remission: _____</p> <p><input type="checkbox"/> Organ transplant <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Artificial joint or heart valve <input type="checkbox"/> Heart disease / Heart attack <input type="checkbox"/> Stroke / TIA <input type="checkbox"/> Cold sores <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Asthma / hay fever / hives / sinus problems <input type="checkbox"/> Heart burn / ulcers / reflux disease <input type="checkbox"/> Kidney disease <input type="checkbox"/> Renal failure <input type="checkbox"/> Glaucoma <input type="checkbox"/> Diabetes <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Autoimmune disease <input type="checkbox"/> Surgery/hospitalizations If yes, please list: _____ _____</p> <p><input type="checkbox"/> Other: _____</p> | <p>Have any blood relatives ever had any of the following (check all that apply)?</p> <p><input type="checkbox"/> Skin cancer If yes, who: _____</p> <p><input type="checkbox"/> Melanoma If yes, who: _____</p> <p><input type="checkbox"/> Abnormal moles <input type="checkbox"/> Poor healing / keloids <input type="checkbox"/> Psoriasis <input type="checkbox"/> Asthma / hay fever / eczema <input type="checkbox"/> Diabetes <input type="checkbox"/> Other skin disease: _____</p> <p>Are you allergic to any medications? <input type="checkbox"/> No <input type="checkbox"/> Yes (please list medications and reactions): _____</p> <p>Are you currently taking any medications or supplements? <input type="checkbox"/> No <input type="checkbox"/> Yes (please list): _____ _____</p> <p>Social history: Do you smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes (how much): _____</p> <p>Do you drink? <input type="checkbox"/> No <input type="checkbox"/> Yes (how much): _____</p> <p>Do you sunbathe or use tanning beds? <input type="checkbox"/> No <input type="checkbox"/> Yes (how often): _____</p> <p>Do you use sunscreen? <input type="checkbox"/> No <input type="checkbox"/> Yes (what SPF number): _____</p> <p>Female patients only: Are you currently pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes If not pregnant, do you plan to become pregnant in the near future? <input type="checkbox"/> No <input type="checkbox"/> Yes Are you nursing? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> |
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To the best of my knowledge, the information provided on this form is correct. I understand that providing incorrect information may be dangerous to my or my child's health. It is my responsibility to inform the office of any changes in my or my child's medical status.

Patient or Guardian Signature: _____ Date: ____/____/____
Relationship (if other than patient): _____