AboutSkin

Patient Name:

Past Medical History	YES	When?
Anxiety		
Arthritis		
Asthma		
Atrial Fibrillation		
Benign Prostatic Hyperplasia (BPH)		
Bipolar Disorder		
Blood Clots		
Bone Marrow Transplant		
Breast Cancer		
Cataracts		
Colon Cancer		
COPD (Emphysema)		
Coronary Artery Disease		
Depression		
Diabetes (Type I or 2)		
End State Renal Disease		
GERD (Acid Reflux)		
Glaucoma		
Hearing Loss		
Heart Murmur or Mitral Valve Prolapse		
Heart Valve Replacement		
Hepatitis (A or B or C)		
Hypertension (High Blood Pressure)		
HIV/AIDS		
Hypercholesterolemia (High Cholesterol)		
Hyperthyroidism		
Hypothyroidism		
Leukemia		
Lung Cancer		
Lymphoma-Type:		
Pacemaker or Defribrillator		
Polycystic Ovary Syndrome (PCOS)		
Prostate Cancer		
Radiation Treatment		
Seasonal Allergies		
Seizures		
Sexually Transmitted Disease		
Type:		
Stroke		
Other:		

Past Surgical History	YES	When?
Appendix Removed		
Bladder Removed		
Mastectomy (Right or Left or Bilateral)		
Lumpectomy (Right or Left or Bilateral)		
Breast Biopsy (Right or Left or Bilateral)		
Breast Implants		
Colon Cancer Resection		
Diverticulitis		
Irritable Bowel Syndrome		
Gall Bladder Removed		
Coronary Artery Bypass		
PTCA (Angioplasty)		
Heart Valve Replacement (Mechanical or Biological)		
Heart Transplant		
Joint Replacement: Knee (Right or Left or Bilateral)		
Joint Replacement: Hip (Right or Left or Bilateral)		
Kidney Biopsy		
Kidney Removed (Right or Left)		
Kidney Stone Removal		
Kidney Transplant		
Ovaries Removed: Endometriosis		
Ovaries Removed: Cyst		
Ovarian Cancer		
Prostate Cancer		
TURP (Transurethral Resection of the Prostate)		
Skin Biopsy		
Basal Cell Carcinoma Surgery (Mohs or Excision)		
Squamous Cell Carcinoma Surgery (Mohs or Excision)		
Melanoma Surgery		
Spleen Removal		
Testicles Removed (Right or Left or Bilateral)		
Hysterectomy: Fibroids		
Hysterectomy: Uterine Cancer		
None		
Other:		
Accidents/Hospitalizations:		

Social History

Cigarette Smoking:	YES
Never Smoked	
Quit: Former Smoker	
Smoke: Less Than Daily	
Smoke: Daily	

Alcohol Use:	YES
None	
Less than 1 drink per day	
1-2 drinks per day	
3 or more drinks per day	

Skin History	YES
Acne - Duration:	
X-Ray or UV Light Treatment for Acne	
Actinic Keratoses	
Asthma	
Basal Cell Skin Cancer	
Blistering Sunburns	
Dry Skin	
Psoriasis	
Eczema	
Flaking or Itchy Scalp	
Hay Fever/Allergies	
Melanoma	
Poison Ivy	
Precancerous Moles (Atypical Moles)	
Squamous Cell Skin Cancer	
Other:	

Females Only (OB/GYN)	YES
Pregnant: If yes, how many weeks?:	
Breast Feeding	
Planning Pregnancy	

Current Medications	YES
Aspirin (81 mg or 325 mg)	
NSAIDs (Motrin, Ibuprofen, Aleve, Advil)	
Multivitamins/Supplements: **Please list**	

Please list ALL Prescription Medications:

____
____
____
____
____
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____
____

Do you take antibiotics **before** teeth cleanings or dental procedures? **YES** or **NO**

Allergies to medications:

____
____
____

Family History	YES	When?
Melanoma		
If yes, which relative:		

Immediate Family Medical Conditions:
(If yes, please list which family member)

Heart Disease:____________________________
High Blood Pressure: _______________________
High Cholesterol:__________________________
Diabetes:________________________________
Asthma:_________________________________
Arthritis:________________________________
Breast Cancer:____________________________
Prostate Cancer:__________________________
Other:__________________________________

Preferred Language:	YES
English	
Spanish	
Other:	

Preferred Contact Method:	YES
Phone	
Email	
Other:	

Race:	YES
White	
Black/African American	
Asian	
American Indian or Native Alaskan	
Native Hawaiian/Pacific Islander	
Unknown	

Ethnicity:	YES
Hispanic/Latino	
Non-Hispanic/Non-Latino	
Unknown	

Pharmacy:
Name: ______________________________
Phone #: ____________________________ (required)
Cross streets: _________________________

Marital Status: ____________________________

Name: ______________________________ DOB:_______________

Signature: ____________________________________