**Medical History Form**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

How did you hear about Lakes Dermatology? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary care doctor/Clinic:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you used any treatments for this condition? If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last skin check? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History**

***Please check if you have a history of the following:***

☐ Anxiety

☐ Arthritis

☐ Asthma

☐ Atrial Fibrillation

☐ Autoimmune disease

☐ Bone Marrow Transplantation

☐ Breast Cancer

☐ Bleeding disorder

☐ Colon Cancer

☐ COPD

☐ Depression

☐ Diabetes

☐ Kidney disease

☐ GERD or reflux ☐ Hearing loss

☐ Hepatitis

☐ High Blood Pressure

☐ HSV/cold sores

☐ HIV/AIDS

☐ High Cholesterol

☐ Joint Replacement

within last 2 years

☐ Thyroid disease

☐ Leukemia

☐ Lung Cancer

☐ Lymphoma

☐ Radiation treatment

☐ Seizures

☐ Stroke

☐ Other

Cancer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­­­

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received a Flu vaccination in the last year? ☐ YES or ☐ NO

If not, please state reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If over age 65, have you ever received a Pneumococcal vaccination? ☐ YES or ☐ NO

**Skin Disease History**

***Please check if you have a History of the following:***

☐ Acne

☐ Actinic Keratoses

☐ Basal Cell Skin Cancer

☐ Blistering Sunburns

☐ Dry skin

☐ Eczema

☐ Hay fever or allergies

☐ Melanoma

☐ Poison Ivy

☐ Precancerous moles

☐ Psoriasis

☐ Squamous Cell Skin Cancer

☐ Flaky/itchy scalp

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

Do you have a family history of Melanoma? ☐ No ☐Yes:

Whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a family history of other skin cancer? ☐ No ☐ Yes

Whom and type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Family History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant or planning a pregnancy? ☐ No ☐ Yes

Are you breastfeeding? ☐ No ☐ Yes

Are you on birth control? ☐No ☐ Yes What Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you wear sunscreen? ☐ No ☐ Yes SPF: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever used a tanning bed? ☐ No ☐ Yes If yes, how often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently use tobacco? ☐ No ☐ Yes

If yes, type of tobacco and frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you a former tobacco user? ☐ No ☐ Yes

If yes, type of tobacco used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use alcohol? ☐ No ☐ Yes

**Medications**

Name Dose Route (eg oral) Frequency (eg twice daily)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*Please attach a separate list or give to your nurse, if needed*

**Medication or Other Medical Allergies (check all that apply)**

☐ Latex ☐ Adhesives ☐ Lidocaine or numbing medication ☐ I have allergies to the following medications (please list):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ No allergies to medications

**Do you have any of the following symptoms?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Fever or chills | ☐No ☐Yes | Abdominal pain | ☐No ☐Yes |  | ☐No ☐Yes |
| Night sweats | ☐No ☐Yes | Nausea or vomiting | ☐No ☐Yes |  | ☐No ☐Yes |
| Fatigue | ☐No ☐Yes | Constipation or diarrhea | ☐No ☐Yes |  | ☐No ☐Yes |
| Unexplained weight loss | ☐No ☐Yes | Rash or itchy skin | ☐No ☐Yes |  | ☐No ☐Yes |
| Swollen lymph nodes | ☐No ☐Yes | Problems with scarring | ☐No ☐Yes |  | ☐No ☐Yes |
| Joint pain | ☐No ☐Yes | Seasonal allergies | ☐No ☐Yes |  | ☐No ☐Yes |
| Muscle Weakness | ☐No ☐Yes | Depression or Anxiety | ☐No ☐Yes |  |  |
| Headaches | ☐No ☐Yes | Immunosuppression | ☐No ☐Yes |  | ☐No ☐Yes |
| Seizures | ☐No ☐Yes | Hair loss | ☐No ☐Yes |  |  |
| Blurry vision | ☐No ☐Yes | Blood thinners | ☐No ☐Yes |  |

|  |  |
| --- | --- |
| Chronic cough ☐No ☐Yes | Blood clots ☐No ☐Yes |
| Shortness of breath ☐No ☐Yes | Sore throat ☐No ☐Yes |
| Chest pain ☐No ☐Yes | Artificial heart valve ☐No ☐Yes |
| Pacemaker or defibrillator ☐No ☐Yes | Other Symptoms: ☐No ☐Yes |

List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else in your history that we should be aware of?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of Patient (or Guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If signed by a guardian, please describe the relationship to the patient:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_