Medical Information

Name: _____ Date of visit:_____

Reason for visit: _____

Past Medical History

Basal Cell Carcinoma	☐ Yes ☐ No	Seasonal Allergies	☐ Yes ☐ No
Squamous Cell Carcinoma	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Melanoma	☐ Yes ☐ No	Atopic Dermatitis (Eczema)	☐ Yes ☐ No

Other: _____

Family History

Basal Cell Carcinoma	☐ Yes ☐ No	Seasonal Allergies	☐ Yes ☐ No
Squamous Cell Carcinoma	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Melanoma	☐ Yes ☐ No	Atopic Dermatitis (Eczema)	☐ Yes ☐ No

Other: _____

Social History

Occupation: _____

Smoking Status: ☐ Never Smoker ☐ Former Smoker ☐ Current Smoker How often? _____
If currently a smoker, are you interested in a smoking cessation? ☐No ☐Yes

Alcohol: ☐ No ☐ Yes How often? _____

Current Vaccinations: Influenza ☐ No ☐ Yes Date: _____ Where: _____
Pneumonia ☐ No ☐ Yes Date: _____ Where: _____

Current weight: _____ Current height: _____

Review of Systems

(Please describe any <u>current</u> problems in the following body systems; describe positive responses on the right)

Constitutional (fever, unintentional weight loss)	☐ Yes ☐ No	_____
Eyes (discharge, dry eyes)	☐ Yes ☐ No	_____
Ears, Nose, Mouth, Throat (any problems?)	☐ Yes ☐ No	_____
Cardiovascular (chest pain, palpitations)	☐ Yes ☐ No	_____
Respiratory (wheezing, shortness of breath)	☐ Yes ☐ No	_____
Gastrointestinal (diarrhea, nausea, vomiting)	☐ Yes ☐ No	_____
Genitourinary (urination, pelvic cramps, discharge)	☐ Yes ☐ No	_____
Musculoskeletal (joint pain, muscle aches)	☐ Yes ☐ No	_____

Neurological (damaged nerves, speech problems) ☐ Yes ☐ No _____

Psychiatric (depression, anxiety) ☐ Yes ☐ No _____

Endocrine (diabetes, thyroid problems) ☐ Yes ☐ No _____

Hematologic/lymphatic (anemia, leg swelling) ☐ Yes ☐ No _____

Allergic/Immunologic (any problems) ☐ Yes ☐ No _____

Current Skin Complaints

New or changing moles ☐ Yes ☐ No (where?)_____

Rash ☐ Yes ☐ No (where?)_____

Warts ☐ Yes ☐ No (where?)_____

Acne ☐ Yes ☐ No (where?)_____

Hair loss ☐ Yes ☐ No (describe) _____

Nail disorder ☐ Yes ☐ No (describe) _____

Psoriasis ☐ Yes ☐ No (where?)_____

Cosmetic concerns ☐ Yes ☐ No (describe) _____

Other skin issues ☐ Yes ☐ No (where?)_____

Medications

(*List all <u>current</u> medications including creams, over-the-counter meds, vitamins, herbal supplements, suppositories, eye drops, etc)*

_____

_____

(If you are being evaluated for a rash or skin allergy, list all other medications <u>taken at any time during the past 6 months</u>)

_____

Medication Allergies _____

_____ ☐ No known drug allergies

Pharmacy Information

(Please provide information for your preferred pharmacy)

Name of Pharmacy: _____ City: _____

Address (or intersection):_____

Signed: _____ Date: _____