

MEDICAL HISTORY

Name: _____ DOB: _____ Age: _____ Sex: _____

Primary Care Physician: _____

Address: _____

Phone Number: _____

Referring Physician: _____

Address: _____

Phone Number: _____

Allergies to Food or Medication:

1: _____ 2: _____ 3: _____

Current Medications (Include Non-Prescription Medications and Birth Control Pills):

1: _____ 4: _____

2: _____ 5: _____

3: _____ 6: _____

Do you have or have you had (please check):

| In the past: | Yes | No |
|------------------------------|-------|-------|
| 1. Skin Disease | | |
| a. Eczema | _____ | _____ |
| b. Psoriasis | _____ | _____ |
| c. Skin Cancer | _____ | _____ |
| d. Acne | _____ | _____ |
| 2. Diabetes | _____ | _____ |
| 3. Hypertension | _____ | _____ |
| 4. Heart Problems | _____ | _____ |
| 5. Heart Valve Problems | _____ | _____ |
| 6. Hay Fever | _____ | _____ |
| 7. Asthma | _____ | _____ |
| 8. Kidney Problems | _____ | _____ |
| 9. Liver Disease | _____ | _____ |
| 10. Psychiatric Illness | _____ | _____ |
| 11. Cancer (Other than skin) | _____ | _____ |
| 12. Seizures | _____ | _____ |
| 13. Bleeding Disorder | _____ | _____ |
| 14. Clotting Disorder | _____ | _____ |

List the surgeries (Operations)

1: _____

2: _____

3: _____

4: _____

5: _____

6: _____

Have you had surgery in the past three months? Y____ N____

Have you had surgery for skin cancer? Y____ N____

Any Medical Conditions not listed above? _____

Have you had any of the following conditions:
(please check)

In the past 3 months?

Yes No

- | | | |
|-------------------------|-------|-------|
| Breathing Problems | _____ | _____ |
| Respiratory Infections | _____ | _____ |
| Persistent Cough | _____ | _____ |
| Shortness of Breath | _____ | _____ |
| Angina/Chest Pain | _____ | _____ |
| High Blood Pressure | _____ | _____ |
| Bloody or Dark Stools | _____ | _____ |
| Diarrhea | _____ | _____ |
| Nausea or Vomiting | _____ | _____ |
| Painful Urination | _____ | _____ |
| Blood in Urine | _____ | _____ |
| Abdominal Pain | _____ | _____ |
| Jaundice | _____ | _____ |
| Arthritis | _____ | _____ |
| Fever | _____ | _____ |
| Headache | _____ | _____ |
| Visual Changes | _____ | _____ |
| Fatigue | _____ | _____ |
| Muscle Weakness | _____ | _____ |
| Anemia | _____ | _____ |
| Thyroid Problems | _____ | _____ |
| Dizziness or Passed Out | _____ | _____ |
| Other (please explain): | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Do you have a family history of:
(please check)

Yes No

- | | | |
|------------------------|-------|-------|
| 1. Eczema | _____ | _____ |
| 2. Hay Fever | _____ | _____ |
| 3. Psoriasis | _____ | _____ |
| 4. Skin Cancer | _____ | _____ |
| Type: _____ | | |
| 5. Other: (list) _____ | | |
| _____ | | |
| _____ | | |

Do you smoke: Yes _____ No _____

- a. How much _____
b. How long _____

Do you drink alcohol: Yes _____ No _____

- a. How much _____

Occupation _____

For Women:

1. Age of first period _____
2. Are your periods regular? _____
3. Date of last period _____
4. Have you ever been pregnant? _____
5. How many times have you been pregnant? _____
6. Are you currently pregnant? _____
7. Age of Menopause _____

Patient/Parent Signature

Date

Physician Signature

Date