Medical History

Name: ____________________

Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplantation
BPH
Breast Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood Pressure
HIV / AIDS
High Cholesterol
Leukemia
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Thyroid Problems

NONE
Other: ____________________

Past Surgical History: (Please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallblader Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE
Other: ____________________

Skin Disease History: (Please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburn
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever / Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

NONE
Other: ____________________

Do you wear sunscreen? Yes No — If yes, what SPF? __________
Do you tan in a tanning salon? Yes No
Do you have a family history of Melanoma? Yes No — If yes, which relative? __________

Medications: (please enter all current medications)

____________________ ____________________
____________________ ____________________
____________________ ____________________

Allergies: (please enter all allergies)

____________________ ____________________
____________________ ____________________
____________________ ____________________

PREMIER DERMATOLOGY PARTNERS®

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker
Other: ______

Alcohol Use (EtOH):
EtOH - NONE
EtOH - less than 1 drink per day
EtOH - 1-2 drinks per day
EtOH - 3 or more drinks per day

Family History of Illness: (Only first degree relatives)

______
______

Preferred Language: ______ Race: ______ Ethnic Group: ______
*Preferred Pharmacy Name: ______
Phone #: ______ City or Zip Code: ______

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Symptom	Yes	No
Abdominal Pain		
Anxiety		
Bleeding Problems		
Bloody Stool		
Blurry Vision		
Changing Mole		
Chest Pain		
Cough		
Depression		
Fever or Chills		
Headaches		
Hay Fever		
Joint Aches		
Muscle Weakness		
Neck Stiffness		
Night Sweats		
Rash		
Seizures		
Shortness of Breath		
Sore Throat		
Thyroid Problems		
Unintentional Weight Gain		
Wheezing		

Other Symptoms: ______

Alerts: (Please circle all that apply)

Allergy to Adhesive
Allergy to Lidocaine
Allergy to Topical Antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator

MRSA
Pacemaker
Require antibiotics prior to surgical procedure
Rapid heartbeat with epinephrine
Are you pregnant or currently trying to get pregnant?
Are you pregnant?
Are you breast feeding?

Other Symptoms: ______

Signature: ______ Date: ______