

The Dermatology & Skin Cancer Center, PA

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MEDICAL HISTORY

Patient Name: _____ **Date:** _____

Primary Care Physician: _____ Referring MD: _____

Reason for today's visit: _____

Do you develop skin rashes in reaction to medications food environment? If so, list: _____

What is your occupation? _____

Hobbies? _____

What medications/vitamins do you take? _____

Preferred Pharmacy Name: _____

Pharmacy Phone Number: _____

YES NO

Are you allergic to any medications?
Which ones? _____

Describe your reaction: _____

Are you in good general health?

HAVE YOU HAD:

- Local anesthesia (Novocaine or Xylocaine) by a dentist or doctor?
- General anesthesia?
- An adverse reaction to either local or general anesthesia?
- A gain or loss of more than 15 pounds in your body weight
- Skin cancer
- Excessive scarring
- Skin diseases. If so, please list: _____

- Problems with healing
- Keloids (raised scars after surgery)
- Bleeding tendency/excessive bruising
- Bladder problems (frequency, burning)
- Stomach problems
- Nausea, vomiting, diarrhea with medications
- Blood clots/inflammation of veins

PLEASE LIST PREVIOUS SURGERIES AND DATES:

DO ANY FAMILY MEMBERS HAVE/HAD: (Check box if yes)

- Heart disease
- Excessive scarring
- Diabetes
- Reaction to anesthesia
- Tuberculosis
- Excessive bleeding tendency
- Skin cancer (type: _____)
- Other forms of cancer (list: _____)

HAVE YOU HAD:

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure or related problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver, gallbladder, problems |
| <input type="checkbox"/> | <input type="checkbox"/> | "yellow Jaundice", Hepatitis problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack/disease/murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes/cold sores |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach problems, indigestion or ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | A pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Any part of your body paralyzed or numb |
| <input type="checkbox"/> | <input type="checkbox"/> | Yeast infection when taking antibiotics |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy-convulsions or seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Broken bones of the face, neck, jaw, back |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis, joint or back problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal chest x-rays |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal electrocardiogram (ECG) |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma or other respiratory problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Medical treatment for nervous condition |
| <input type="checkbox"/> | <input type="checkbox"/> | Hernia |
| <input type="checkbox"/> | <input type="checkbox"/> | Any other illnesses. If so please list: _____ |

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Cataracts |
| <input type="checkbox"/> | <input type="checkbox"/> | Dry eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | History of blood clots in legs or lungs |
| <input type="checkbox"/> | <input type="checkbox"/> | History of legs swelling/edema |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial joints |

DO YOU/ARE YOU:

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Exercise regularly? |
| <input type="checkbox"/> | <input type="checkbox"/> | Wear contact lenses? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have a pacemaker? |
| <input type="checkbox"/> | <input type="checkbox"/> | Smoke? How much? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Drink alcohol? Drinks/week: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have HIV or AIDS? |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnant? Due date: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have any contagious/infectious diseases? |

Patient Signature Date

Reviewed by Date