DermacenterMD

Medical History Form

(please complete both sides of form)

Patient Name: _____ **Date:** _____

Have you been seen in our office before? _____ **Yes** _____ **No**

Why are we seeing you today? _____ Rash or Psoriasis _____ Mole, Growth or Lesion _____ Acne or Rosacea

_____ Other: _____

What locations are involved? _____ Face _____ Arms (Upper extremities) _____ Legs (lower extremities)

_____ Torso _____ Head _____ Other: _____

How would you describe the problem? (check all that apply)

_____ no symptoms _____ flaking _____ itching _____ painful _____ red
_____ changing color _____ enlarging _____ new _____ not healing _____ rough/raised
_____ scaling _____ stable _____ tender _____ Other: _____

How would you rate the problem/concern? (select one)

_____ Mild (a good day today for the problem or area of concern)
_____ Moderate (an average day for the problem or area of concern)
_____ Severe (a bad day for the problem or area of cancer)

Have you had any of the following? (check all that apply)

_____ blisters _____ chills _____ cough _____ diarrhea _____ fever _____ joint aches
_____ recent illness _____ household contacts with similar problem _____ new personal care products
_____ other contributing factors: _____

What have you tried to treat the problem? (check all that apply)

_____ topical antibiotic _____ topical anti-fungal or anti-yeast cream
_____ oral antibiotic (which ones): _____
_____ topical steroid (which ones): _____
_____ freezing (cryosurgery) _____ biopsy _____ surgery
_____ other: _____

Do you have a history of any of the following? (check all that apply)

_____ actinic keratosis _____ atypical nevi (abnormal moles) _____ basal cell carcinoma
_____ melanoma in you _____ previous skin cancer _____ squamous cell carcinoma
_____ melanoma in family _____ there is no history of these issues in myself or my family

If you have ACNE or ROSACEA select items which describe your condition best? (check all that apply)

_____ pimples _____ cysts/nodules _____ pigmentation or scarring
_____ dry face _____ abnormal menses _____ worse around menstrual cycle
_____ oily face _____ family history of acne _____ history of accutane use
_____ normal menses _____ oral contraceptive _____ other: _____

Please feel free to provide any other helpful information: _____

_____

_____

PLEASE TURN OVER AND COMPLETE OTHER SIDE OF FORM

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(please complete both sides of form)

Do you currently have or have you had any of the following (check all that apply):

____ None of these items

____ Anxiety	____ Breast Cancer	____ End Stg Renal Dis.	____ High Cholesterol	____ Prostate Cancer
____ Arthritis	____ Colon Cancer	____ GERD	____ High Thyroid (Hyper)	____ Radiation Treat.
____ Asthma	____ COPD	____ Hearing Loss	____ Low Thyroid (Hypo)	____ Seizures
____ Atrial Fribrillation	____ Coronary Art. Dis.	____ Hepatitis	____ Leukemia	____ Stroke
____ Bone M. Transplnt	____ Depression	____ Hypertension	____ Lung Cancer	____ Other (specify):___
____ BPH	____ Diabetes	____ HIV/AIDS	____ Lymphoma	_____

Please list any prior surgeries: _____

Have you had any of the following conditions (check all that apply)?

____ None

____ Acne	____ Basal Cell Cancer	____ Eczema	____ Melanoma	____ Psoriasis
____ Actinic Keratosis	____ Bistering Sunburn	____ Flaking/Itch Scalp	____ Poison Ivy	____ Squamous Cell Canc
____ Asthma	____ Dry Skin	____ Hay Fever/Allergies	____ Precancer Moles	____ Other:_____

Family History:

Do you have a family history of Melanoma? ____ Yes ____ No If yes, which relative: _____

Please list your medications: _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Please list your medication ALLERGIES: _____

Please complete your smoking and alcohol history:

Smoking History: ____ Currently Smoke Daily ____ Former Smoker ____ Never A Smoker

If You Do/Did Smoke: How Many Packs Per Day: _____ Total years Smoking _____

Alcohol Use: ____ None ____ Less Than 1 Drink Daily ____ 3 Or More Drinks Daily

Please select Yes or No for the following Symptoms:

____ Yes	____ No	Problems Healing	____ Yes	____ No	Fever or Chills
____ Yes	____ No	Problems with Bleeding	____ Yes	____ No	Leg Swelling
____ Yes	____ No	Hay Fever	____ Yes	____ No	Blurry Vision
____ Yes	____ No	Headaches	____ Yes	____ No	Sore Throat
____ Yes	____ No	Abdominal Pain (nausea/vomit)	____ Yes	____ No	Cough
____ Yes	____ No	Joint Aches	____ Yes	____ No	Depression

Do you have: ____ Pace Maker ____ Artificial Heart Valve

Please list any other medical problems: _____

_____

_____

_____

_____

PLEASE TURN OVER AND COMPLETE OTHER SIDE OF FORM