Name:_____ **Age**_____ **Gender : F M**

Social Status: ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Widowed

Do you have children? ☐ Yes ☐ No How many? _____

This history is given by ☐ Self ☐ Parent ☐ Guardian ☐ Self through interpreter

Reason for Appointment:_____

We realize that you may have several skin issues that you would like to discuss with the doctor. We will make our best effort to address all of them over time. For *today's appointment please choose the one issue that is most urgent to you to be addressed.* Once your current condition is treated, we recommend a detailed full body skin exam. Complete skin checks will allow the doctor to identify suspicious lesions and skin diseases which could be treated *at future appointments*. Prior to seeing the doctor, the medical assistant (MA) will ask you questions regarding today's visit. Try to be as detailed as possible. *The doctor will only address issues that were prescreened by the MA*. For additional concerns, future appointments will be scheduled. _____Initials

Do you drink alcohol? ☐ **Yes** ☐ **No**
Type: Wine/Beer/Cocktail/ Drinks # per day_____ Social drinker

Do you use or have you ever used drugs other then ordered by MD? ☐ **Yes** ☐ **No**
Type: Amphetamine/Cocaine/Benzodiazepines/Marijuana/Opiate

Do you use tobacco? ☐ **Yes** ☐ **No** Packs #per day _____

Have you ever had skin cancer? ☐ **Yes** ☐ **No**
Type: Melanoma Basal Cell Carcinoma Squamous Cell Carcinoma Actinic Keratosis Unsure

Have anyone in your family had skin cancer? ☐ **Yes** ☐ **No** Relation:_____
Type: Melanoma Basal Cell Carcinoma Squamous Cell Carcinoma Actinic Keratosis Unsure

Do you have history of any other skin disease: ☐ **Yes** ☐ **No**
Describe

Do you have pacemaker? ☐ **Yes** ☐ **No** How long ago was it placed? _____

Do you have artificial joints? ☐ **Yes** ☐ **No** Since when? _____

Have you ever had adverse reaction to local anesthesia? ☐ **Yes** ☐ **No**
Please explain:

Do you bleed easily? ☐ **Yes** ☐ **No**

Occupation? _____

FEMALES ONLY: Are you pregnant? ☐ **Yes** ☐ **No**

CURRENT MEDICATIONS :

Medication Name	**Dose and Frequency**

If you have your own pre-made medication list please give it to the receptionist. Whenever there are updates to your medications, please notify the nurse so your chart can be updated

ALLERGIES:

Medication Name	**Reaction to Medication**

REVIEW OF SYSTEMS/PAST MEDICAL HISTORY

PLEASE CICRLE IF YOU HAVE OR EVER HAD ANY OF THE FOLLOWING:

Cardiovascular
Artificial Valves
Chest Pain
Defibrillator
Hypertension
Irregular Heartbeat
Pacemaker
Palpitations

General
Chronic fevers
Chronic chills
Chronic weakness
Chronic weakness
Chronic fatigue
Recent weight change

Endocrine
Thyroid problems
Diabetes
Heat or Cold Intolerance
Excessive Thirst/Hunger
Excessive Sweating

ENT
Cataract
Color Blindness
Dizziness
Glaucoma
Hearing Difficulty
Vertigo

Gastrointestinal
Abdominal Pain
Colon Cancer
Constipation
Diarrhea
Heartburn
Indigestion
Nausea
Reflux
Trouble Swallowing
Vomiting

Genitourinary
Blood In Urine
Flank Stone
Kidney Disease
Pelvic Pain
Urinary Infection

Hematological
Blood Transfusions
Clotting Problems
Hepatitis

Immunologic
AIDS or HIV Positive
Allergy
Allergy Treatment
Chicken Pox
Family Hx Allergic Disease
Measles
Mononucleosis
Organ Transplants
Typhoid Fever

Integumentary
Skin Color Changes
Dryness
Hair & Nail Changes
Keloid Tendency
History of Melanoma
History of Skin Cancer
Sores
Rashes

Musculoskeletal
Arthritis Joint Deformity
Arthritis of Rheumatism
Bone or Joint Disease
Gout
Multiple Sclerosis

Neurologic
Dizziness
Epilepsy
Migraine Headaches
Motion Sickness
Meningitis
Polio

Psychiatric
Hx Psychiatric Care
Depression
Mental Disorder
Nervous Disorder

Respiratory
Asthma
Bronchitis
Emphysema
Influenza
Pleurisy
Pneumonia
Tuberculosis
Tuberculosis or Exposure