dermatology CONSULTANTS

Medical History Form

Patient Label Here

Name: _____ Preferred Name: _____ DOB: _____

Primary Care Physician: _____ Referring Physician: _____

1.What is the reason for your visit today?

Concern: _____ Body Location: _____ Duration: _____ Past Treatments: _____

2. Do you have a PERSONAL history of:

	Yes	No	
Melanoma	☐	☐	Details: _____
Basal cell or Squamous cell carcinoma	☐	☐	Details: _____
Pre-cancerous skin lesions	☐	☐	Details: _____

3. Past Medical History:

	Yes	No		Yes	No
Cancer (other than skin cancer): Type/Date: _____	☐	☐	Organ transplant: Type/Date: _____	☐	☐
Psoriasis	☐	☐	□ Leukemia / □ CLL	☐	☐
Eczema	☐	☐	Herpes simplex (cold sores)	☐	☐
Asthma	☐	☐	Hepatitis	☐	☐
Hay fever	☐	☐	HIV positive	☐	☐
Lupus	☐	☐	MRSA	☐	☐
Heart disease	☐	☐	Anticoagulant treatment	☐	☐
Diabetes	☐	☐	Bleeding disorder	☐	☐
□ Depression/□ Anxiety	☐	☐	□ Blood clots / □ Pulmonary embolism	☐	☐
Kidney disease	☐	☐	Artificial joint Type/Date: _____	☐	☐
Thyroid disease	☐	☐	Artificial heart valve	☐	☐
Rheumatoid arthritis	☐	☐	Mitral valve prolapse	☐	☐
Ulcerative colitis or Crohn's	☐	☐	Pre-op / dental antibiotics	☐	☐
Stomach ulcers	☐	☐	Fainting with procedures	☐	☐
Multiple sclerosis or Myasthenia gravis	☐	☐	Pre-op / dental antibiotics	☐	☐
Parkinson's disease	☐	☐	Keloid Scars	☐	☐
Liver Disease	☐	☐	Pacemaker	☐	☐
Other Autoimmune Disease Please List: _____	☐	☐	Defibrillator	☐	☐

Any other medical conditions not listed above:

_____

4. Current medications:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

5. Allergies:

_____

Continue on 2nd side

6. The following information is collected for providing healthcare only.

Sex assigned at birth: □ Male □ Female

Gender identity: □ Male □ Female □ Transgender Male □ Transgender Female □ Non-binary □ Other: _____

Preferred pronouns: □ She/her □ He/him □ They/them □ Other: _____

	Yes	No	Unsure
Current Flu Vaccine:	☐	☐	☐
Current Pneumococcal vaccine	☐	☐	☐

For patients under 18 years old: Height: _____ Weight_____

7. For Patients Who Can Get Pregnant Only:

	Yes	No	
Are you currently trying to get pregnant?	☐	☐	
Are you currently pregnant?	☐	☐	Due Date: _____
Are you currently breastfeeding?	☐	☐	
Are you taking birth control or have an IUD?	☐	☐	Type: _____
Do you have regular menstrual cycles?	☐	☐	

8. Family History:

	Yes	No	
Do you have a family history of melanoma?	☐	☐	Details: _____
Do you have a family history of other (non-melanoma) skin cancer?	☐	☐	Details: _____
Do you have a family history of psoriasis?	☐	☐	
Do you have a family history of eczema?	☐	☐	

9. Review of Systems:

	Yes	No		Yes	No		Yes	No
Fever	☐	☐	Shortness of breath	☐	☐	Swollen lymph nodes	☐	☐
Chills	☐	☐	Nausea / Vomiting	☐	☐	Joint pain	☐	☐
Fatigue	☐	☐	Abdominal pain	☐	☐	Rash / Itch	☐	☐
Unintentional Weight loss	☐	☐	Diarrhea	☐	☐	Headache	☐	☐
			Constipation	☐	☐	Anxiety	☐	☐
Eye irritation	☐	☐	Easy bruising	☐	☐	Depression	☐	☐
Chronic cough	☐	☐	Blood clots	☐	☐			

10. Social History:

Occupation: _____ Hobbies: _____

Tobacco use: □ Yes □ No □ Former

Alcohol: □ more than 5 drinks/day □ more than 4 drinks/day □ Occasional/Social □ None

Tanning Bed Use □ Yes □ No □ Past

Blistering Sunburns (Past) □ Yes □ No

Sunscreen Use □ Yes □ No

11. Preferred Pharmacy: _____