



**PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY FORM**

NAME: \_\_\_\_\_ DATE OF VISIT: \_\_\_/\_\_\_/\_\_\_ DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ AGE: \_\_\_\_\_ SEX:  M  F  
 Occupation (if retired, prior occupation): \_\_\_\_\_ Referred by:  Self/friend  Internet  Consult requested by Dr. \_\_\_\_\_  
 Reason for today's visit: \_\_\_\_\_ CC  
 Symptoms of today's problem: \_\_\_\_\_ HPI  
 Skin areas involved: \_\_\_\_\_ LOC  
 How long has the problem been present? \_\_\_\_\_ DUR  
 Was there any previous treatment?  No  Yes If yes, when? \_\_\_\_\_ Type? \_\_\_\_\_ TIMING  
 Was a biopsy done?  No  Yes If yes, when? \_\_\_\_\_  Biopsy done by referring Dr.  Other Dr. \_\_\_\_\_ CONTEXT

**CHECK ALL THAT APPLY TO TODAY'S PROBLEM**

- |   |  |  |
|---|--|--|
| <p><b>QUALITY</b></p> <p>A change in <input type="checkbox"/> size<br/> <input type="checkbox"/> elevation<br/> <input type="checkbox"/> other _____<br/> <input type="checkbox"/> none</p> | <p><b>ASSOCIATED SYMPTOMS</b></p> <p><input type="checkbox"/> bleeding <input type="checkbox"/> infection<br/> <input type="checkbox"/> tingling <input type="checkbox"/> itching<br/> <input type="checkbox"/> pain <input type="checkbox"/> other _____<br/> <input type="checkbox"/> ulceration <input type="checkbox"/> none</p> | <p><b>SEVERITY</b></p> <p><input type="checkbox"/> no symptoms<br/> <input type="checkbox"/> occasional symptoms<br/> <input type="checkbox"/> constant symptoms</p> |
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**SYSTEM REVIEW: Check all that apply regarding your health and any other important problems**

**MEDICATIONS** (include over-the-counter medications): \_\_\_\_\_

**MEDICATION ALLERGIES:** \_\_\_\_\_

- |   |  |   |  |
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| <p><b>SKIN</b></p> <p><input type="checkbox"/> Abnormal scarring<br/> <input type="checkbox"/> Keloids (Where? _____)<br/> <input type="checkbox"/> Poor healing<br/> <input type="checkbox"/> History of new or changing mole</p> <p><b>INFECTIONS</b></p> <p><input type="checkbox"/> None<br/> <input type="checkbox"/> Colds sores/Fever blisters/Herpes<br/> <input type="checkbox"/> Hepatitis/Jaundice<br/> <input type="checkbox"/> HIV/AIDS<br/> <input type="checkbox"/> Tuberculosis (TB)<br/> <input type="checkbox"/> Immunosuppression<br/> <input type="checkbox"/> Other _____</p> <p><b>CONSTITUTIONAL SYMPTOMS</b></p> <p><input type="checkbox"/> None<br/> <input type="checkbox"/> Weight loss<br/> <input type="checkbox"/> Fever<br/> <input type="checkbox"/> Dizziness or fainting<br/> <input type="checkbox"/> Other _____</p> | <p><b>CARDIOVASCULAR</b></p> <p><input type="checkbox"/> Normal<br/> <input type="checkbox"/> High blood pressure<br/> <input type="checkbox"/> Heart murmur<br/> <input type="checkbox"/> Artificial heart valve<br/> <input type="checkbox"/> Arrhythmia (irregular heart beat)<br/> <input type="checkbox"/> Pacemaker<br/> <input type="checkbox"/> Defibrillator<br/> <input type="checkbox"/> Angina (chest pain)<br/> <input type="checkbox"/> Heart attack (When? _____)<br/> <input type="checkbox"/> Heart transplant<br/> <input type="checkbox"/> Other _____</p> <p><b>ENDOCRINE</b></p> <p><input type="checkbox"/> Normal<br/> <input type="checkbox"/> Diabetes<br/> <input type="checkbox"/> Thyroid disease<br/> <input type="checkbox"/> Kidney disease<br/> <input type="checkbox"/> Kidney transplant<br/> <input type="checkbox"/> Other _____</p> | <p><b>GASTROINTESTINAL</b></p> <p><input type="checkbox"/> Normal<br/> <input type="checkbox"/> Stomach ulcer<br/> <input type="checkbox"/> Colitis<br/> <input type="checkbox"/> Liver damage<br/> <input type="checkbox"/> Liver transplant<br/> <input type="checkbox"/> Other _____</p> <p><b>HEMATOLOGIC / LYMPHATIC</b></p> <p><input type="checkbox"/> Normal<br/> <input type="checkbox"/> Anemia<br/> <input type="checkbox"/> Bleeding problems<br/> <input type="checkbox"/> Enlarged lymph nodes<br/> <input type="checkbox"/> Arsenic exposure<br/> <input type="checkbox"/> Other _____</p> <p><b>MUSCULOSKELETAL</b></p> <p><input type="checkbox"/> Normal<br/> <input type="checkbox"/> Arthritis<br/> <input type="checkbox"/> Artificial joint<br/> <input type="checkbox"/> Other _____</p> | <p><b>NEUROLOGICAL</b></p> <p><input type="checkbox"/> Normal<br/> <input type="checkbox"/> Stroke<br/> <input type="checkbox"/> Seizures<br/> <input type="checkbox"/> Other _____</p> <p><b>PSYCHIATRIC</b></p> <p><input type="checkbox"/> Normal<br/> <input type="checkbox"/> Anxiety attacks<br/> <input type="checkbox"/> Depression<br/> <input type="checkbox"/> Other _____</p> <p><b>RESPIRATORY</b></p> <p><input type="checkbox"/> Normal<br/> <input type="checkbox"/> Asthma<br/> <input type="checkbox"/> Emphysema / Chronic bronchitis<br/> <input type="checkbox"/> Other _____</p> <p><b>EARS / EYES / NOSE / THROAT</b></p> <p><input type="checkbox"/> Normal<br/> <input type="checkbox"/> Glaucoma<br/> <input type="checkbox"/> Other _____</p> |
|---|--|---|--|

**PAST HISTORY** Do you take antibiotics before undergoing dental procedures?  No  Yes [Prophylactics abx.  indicated  not indicated for skin surgery]

Have you ever received blood transfusions?  No  Yes If, yes, when? \_\_\_\_\_

Previous skin cancer:  None  List: \_\_\_\_\_

X-ray treatment (not routine dental or chest x-rays)?  No  Yes If yes, what for? \_\_\_\_\_ When? \_\_\_\_\_

Ultraviolet light treatment:  No  Yes If yes,  Tanning bed (UVA)  UVB  PUVA  Other \_\_\_\_\_

Major illnesses, hospitalizations and surgeries (include year and reason): \_\_\_\_\_

**FAMILY HISTORY** Skin cancer:  None  Melanoma  Basal cell  Squamous cell  Other \_\_\_\_\_

**SOCIAL HISTORY** Do you wear:  Glasses  Contact lenses  Dentures  Hearing aid Alcohol:  No  Yes If yes, how much? \_\_\_\_\_

Smoking:  No  Former  Yes, packs per day \_\_\_\_\_  Pipe  Cigar  Chewing tobacco  Nicotine tablets/patch

**Reviewed** \_\_\_\_\_