PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY FORM

Name ____ Date ________________

Date of Birth ____________ Sex ☐ M ☐ F Referred by: M.D.(name) _________________ Self/Friend __ Other __

Do you know any of our providers? MCCRAY CHOW STEVENSON

Main skin problem you want evaluated

- o Rash ____
- o Wart ____
- o Acne ____
- o New growth(s) ____________________________________
- o Changing mole(s) _________________________________
- o Full body mole check _____________________________
- o Other ____

1. **Body area:** ______________________ **Duration:** ______________________
2. **Previous treatment (all medicines used):** ☐ None

   ____
3. **Changes:** ☐ color ☐ size ☐ elevation ☐ hardness ☐ none
4. **Modifying factors:** ☐ history of sun exposure ☐ other immune diseases ☐ other illnesses ☐ none
5. **Symptoms:** ☐ bleed ☐ itch ☐ pain ☐ infection ☐ none
6. **Severity:** ☐ none ☐ occasional ☐ constant

Please note all other skin problems you would like evaluated today:

MEDICAL HISTORY (please tick appropriate boxes)

	Artificial joints		Diabetes		Pacemaker
	Stent		High blood pressure		Defibrillator
	Asthma		Stroke		Artificial joints within last 2 years
	Heart attack		Glaucoma		Artificial heart valves
	Chest pain		Seizure history		Premedication prior to procedures
	Abnormal EKG		Cancer		Allergy to adhesives
	Heart Murmur		Hepatitis A B C		Allergy to topical antibiotics
	Mitral valve prolapse		GI upset with antibiotics		Blood thinners
	Endocarditis		Yeast infections with antibiotics		Pregnancy or planning a pregnancy
	Liver or Kidney disease		Rapid heart beat with epinephrine		Allergy to lidocaine

Please elaborate here

DERMATOLOGIC HISTORY (please tick appropriate boxes)

	Acne		Eczema		Psoriasis
	Warts		Skin Cancer – basal cell squamous cell		Actinic Keratoses
	Atypical (pre-malignant moles)		Malignant Melanoma		Family History of Malignant Melanoma
	Nail Disorder		Hair Loss		Easy bruising
	Varicose or spider veins		Keloid or abnormal scarring		Benign mole removals
	Frequent sunburns		Cosmetic Surgery		Hay fever
	Fungal infection		Poison Ivy		Dry Skin
	Other		Other		Other

Please elaborate here

CURRENT MEDICATIONS All prescription, over-the-counter, and vitamins

☐ None

Medication	Strength	How Often	When Started

PREGNANCY ☐ Yes ☐ No ☐ On birth control pills When started? ________________

ALLERGIES ☐ None ☐ No Changes

Medicine Food or Substance	Date onset	Rash	Nausea	Anaphylaxis	Other

SURGICAL HISTORY (include cosmetic procedures)

Condition	Operation	Physician	Date

FAMILY HISTORY

☐ None

☐ Melanoma ☐ Other skin cancer ☐ Diabetes ☐ Hay Fever ☐ Asthma ☐ Psoriasis

☐ Cancer ☐ Eczema ☐ Other____

SOCIAL HISTORY Occupation ____

Marital Status: S M D W

Smoking: Never Former Yes: How many packs/day?

Alcohol: None Less than 1 drink daily 1-2 drinks daily 3 or more drinks daily

Alcohol or drug use or addictions N Y

What is your caffeine use?

Do you wear sunscreen? N Y SPF #________

PHARMACY INFORMATION

CONFIRMED BY: ____ ____

(M.D. or PA-C Signature) **Patient Signature**

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