



Patient Name: _____

Visit Date ___/___/___

Date of Birth: _____

Patient Medical History

Past Medical History: (Please check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GERD | <input type="checkbox"/> Renal Disease |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> COPD | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |

Other _____

Past Surgical Procedures:

- Yes Please list: _____
- No

Skin Disease History: (Please check all that apply)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Flaking/ itching scalp | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Actinic keratosis | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Squamous cell carcinoma |
| <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Precancerous moles | <input type="checkbox"/> None |

Do you wear sunscreen? Yes No If yes, what SPF? _____

Do you use or have a history of using a tanning salon? Yes No

Do you have a family history of melanoma? Yes No If yes, who? _____

Medication <i>Please list all medications. Attach list, if necessary.</i>	Allergies <i>Please list all allergies.</i>	Smoking Status <i>Please check one</i>	Alcohol Use <i>Please check one</i>
1.	1.	<input type="checkbox"/> Unknown	<input type="checkbox"/> Less than 1 drink
2.	2.	<input type="checkbox"/> Currently smokes	<input type="checkbox"/> 1-2 drinks per day
3.	3.	<input type="checkbox"/> Past history of smoking	<input type="checkbox"/> 3 or more drinks per day
4.	4.	<input type="checkbox"/> Never smoked	<input type="checkbox"/> Never

Family History: (Please circle one)

Melanoma Yes No Relative:	Psoriasis Yes No Relative:	Hair Loss Yes No Relative:	Unknown
Skin Cancer Yes No Relative:	Eczema Yes No Relative:	Lupus: Yes No Relative:	Other

Alerts: (Please circle one)

Are you currently pregnant or trying to get pregnant? Yes No