Medical History Form

Please fill out this form and bring it with you to the SkinPros office.

SKINPROS
Your Skin. Our Expertise.

Today's date: / / MD: _____

PATIENT INFORMATION

Patient's last name: _____ First: _____ Middle: _____ Birth date: / /

REASON FOR TODAY'S VISIT

Concern:	Location:	Duration:	Prior Treatments:
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VACCINATIONS

Have you had your influenza vaccine this year? □ Yes □ No Have you had your pneumonia vaccine this year? □ Yes □ No

PAST MEDICAL HISTORY

Adhesive tape allergy	□ Yes □ No	Abnormal scars	□ Yes □ No
Latex allergy	□ Yes □ No	Poor wound healing	□ Yes □ No
Local anesthetics allergy	□ Yes □ No	HSV / cold sore	□ Yes □ No
Epinephrine sensitivity	□ Yes □ No	Eczema	□ Yes □ No
Bacitracin allergy	□ Yes □ No	Asthma	□ Yes □ No
Neosporin allergy	□ Yes □ No	Hay fever	□ Yes □ No
Anticoagulant treatment	□ Yes □ No	Heart disease	□ Yes □ No
Bleeding disorders	□ Yes □ No	Diabetes	□ Yes □ No
Artificial joint	□ Yes □ No	Kidney disease	□ Yes □ No
Artificial heart valves	□ Yes □ No	Thyroid disease	□ Yes □ No
Pacemaker / defibrillator	□ Yes □ No	Lupus	□ Yes □ No
Mitral valve prolapsed	□ Yes □ No	Arthritis	□ Yes □ No
Immunosuppressed	□ Yes □ No	Psoriasis	□ Yes □ No
Organ transplant	□ Yes □ No	Fainting / syncope	□ Yes □ No
CLL Chronic leukemia	□ Yes □ No	Hepatitis	□ Yes □ No
Pre-op/pre-dental antibiotics	□ Yes □ No	HIV positive	□ Yes □ No
Memory problems	□ Yes □ No	MRSA	□ Yes □ No

MELANOMA HISTORY

Do you have a history of melanoma? □ Yes □ No

Do you have a history of other skin cancer(s)? □ Yes □ No

CURRENT MEDICATIONS

Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:

MEDICATION ALLERGIES

Do you have any medication allergies: □ Yes □ No

List allergies: _____

FOR WOMEN ONLY

Are you pregnant? □ Yes □ No

Are you breastfeeding? □ Yes □ No

Are you on birth control? □ Yes □ No

Do you have regular menstrual cycles? □ Yes □ No

FAMILY HISTORY OF MELANOMA

Do you have a family history of melanoma? □ Yes □ No

Do you have a family history of other skin cancer(s)? □ Yes □ No

Types: _____

SOCIAL HISTORY

Occupation: _____

Do you use tobacco? □ Yes □ No

Alcohol consumption? □ Socially □ Moderate □ Heavy

Do you use sunscreen? □ None □ Daily □ Occasionally

Tanning bed use? □ None □ Current □ Previous

Do you have any other medical problems or conditions? _____

ADDITIONAL SYMPTOMS

Fever	□ Yes	□ No	Shortness of breath	□ Yes	□ No	Swollen lymph nodes	□ Yes	□ No
Chills	□ Yes	□ No	Nausea / vomiting	□ Yes	□ No	Joint pain	□ Yes	□ No
Fatigue	□ Yes	□ No	Abdominal pain	□ Yes	□ No	Rash / itch	□ Yes	□ No
Unintentional weight loss	□ Yes	□ No	Diarrhea	□ Yes	□ No	Headache	□ Yes	□ No
Eye Irritation	□ Yes	□ No	Constipation	□ Yes	□ No	Anxiety	□ Yes	□ No
Chronic cough	□ Yes	□ No	Easy bruising	□ Yes	□ No	Depression	□ Yes	□ No
			Blood clots	□ Yes	□ No			