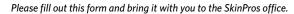
Medical History Form





| Today's date: / / | MD: | | | | |
|------------------------------|---------------------------|-----------------|----------------------|----------------------------|------|
| PATIENT INFORMATION | | | | | |
| Patient's last name: First: | | Middle: | | Birth date: / / | |
| REASON FOR TODA | Y'S VISIT | | | | |
| Concern: | Location: | Duration: | | Prior Treatments: | |
| Concern: | Location: | Duration: | | Prior Treatments: | |
| VACCINATIONS | | | | | |
| Have you had your influenz | a vaccine this year? □ Ye | es □ No Have yo | ou had your pneumoni | a vaccine this year? □ Yes | □ No |
| PAST MEDICAL HIST | ΓORY | | | | |
| Adhesive tape allergy | □ Yes □ No | | Abnormal scars | □ Yes □ No | |
| Latex allergy | □ Yes □ No | | Poor wound heali | ng □ 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 / syncop | e □ Yes □ No | |
| CLL Chronic leukemia | □ Yes □ No | | Hepatitis | □ Yes □ No | |
| Pre-op/pre-dental antibiotic | cs □ Yes □ No | | HIV positive | □ Yes □ No | |
| Memory problems | □ Yes □ No | | MRSA | □ Yes □ No | |

MELANOMA HISTORY

Do you have a history of melanoma? $\ \square$ Yes $\ \square$ No Do you have a history of other skin cancer(s)? $\ \square$ Yes $\ \square$ No

CURRENT MEDICATIONS Medication: Dose: Medication: Dose: Medication: Dose: Medication: Dose: Medication: Medication: Dose: 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 on birth control? □ Yes □ No Are you breastfeeding? Do you have regular menstrual cycles? ☐ Yes □ No □ 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? □ Occasionally □ None □ Daily Tanning bed use? □ None □ Current □ Previous Do you have any other medical problems or conditions? ADDITIONAL SYMPTOMS Shortness of breath Fever □ Yes □ No □ Yes □ No Swollen lymph nodes □ Yes □ No Chills \square Yes \square No □ Yes □ No Nausea / vomiting Joint pain □ Yes □ No **Fatigue** □ Yes □ No Abdominal pain □ Yes □ No Rash / itch □ Yes □ No Diarrhea Headache Unintentional weight loss ☐ Yes ☐ No □ Yes □ No □ Yes □ No Eye Irritation □ Yes □ No Constipation □ Yes □ No Anxiety □ Yes □ No Chronic cough □ Yes □ No Easy bruising Depression □ Yes □ No □ Yes □ No

Blood clots

□ Yes □ No