PATIENT MEDICAL HISTORY FORM

Name: _____ **Date of Birth:** _____

Primary Care Physician: _____ **Age:** _____ **Sex:** Male / Female

Preferred Pharmacy: _____ **Pharmacy phone #:** _____

LAB if required (ple**ase circle)** Ameripath/Dermpath LabCorp Quest Korpath

Current Reason You Are Here Today: _____

MEDICAL HISTORY: (Please circle all that apply)

Anemia	Eye Disease _____	HIV/AIDS
Anxiety/Depression	Excessive Scarring	Hypo/Hyper Thyroid
Arthritis/Rheumatoid or Psoriatic	Gerd	Kidney Problems
Artificial Joints	Heart Attack	Lymphoma
Asthma/COPD	Heart Disease	Pacemaker
Bleeding Disorder	Heart Failure	Radiation Treatments
Cancer/type _____	Heart Valve Replacement	Seizures
Coronary Artery Disease	Hepatitis	Stomach Problems
Chronic Lung Disease	High Blood Pressure	Stroke
Diabetes/type_____	High Cholesterol	NONE OF THE ABOVE

Other: _____

SKIN HISTORY: (Please circle all that apply)

Actinic Keratosis	Dry Skin	Keloid scars	Redness/Dark	Wrinkles
Acne	Eczema	Melanoma	SCC	
BCC (basal cell)	Flaking or itchy	Precancerous	Spots	
Bleeding/Bruising	scalp	Moles	Sunburn	NONE OF THE
Cold Sores	Itching	Psoriasis	(blistering)	ABOVE

If you've previously had skin cancer, please list body location(s)**:** _____

Other skin issues: _____

Do you wear sunscreen? Yes No Do you use indoor tanning? Yes No Never

Number of alcoholic drinks per day (circle) None Less than 1 per day 1-2 per day 3 or more per day

Do you smoke/vape? (circle) Former Never Current (packs/pods per day/week) _____

Any psychiatric problems, nervous breakdown or currently under the care of a psychiatrist? Yes No

Family Medical History of Melanoma? Yes No Who? _____

Family Medical History of Cancer? Yes No Who? _____ Type? _____

Family Medical History of Heart Issues? Yes No Who? _____ Condition? _____

PHYSICAL EXAM: Height_____ Weight _____lbs. Bra Size: _____

OVER

PAST SURGERIES & HOSPITALIZATIONS: (please list all surgeries - including cosmetic)

_____ _____

_____

_____ _____

_____ _____

_____ _____

MEDICATIONS (Please enter all current medications including vitamins and/or supplements including dosages)

MEDICATION	**DOSE** (mg, pill, etc) **&** **Times per day**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

☐ I do not take any medicines, vitamins or supplements

Any ALLERGIES or reactions to medication, anesthesia or LATEX? Yes No

Please explain: _____

Bleeding Tendencies: _____

ALERTS: (Please circle all that apply)

Allergy to adhesive
Allergy to lidocaine
Allergy to Topical Antibiotics
Blood thinner
Bone Marrow Transplant
Defibrillator
Healing Problems
MRSA
Pacemaker
POTS
Pregnancy or planning for in future
Rapid Heart Rate w/Epinephrine
Require Antibiotics prior to surgery

Have you experienced a fall or problem with gait or balance? ☐ **Yes** ☐ **No**

Other: _____