



PATIENT MEDICAL HISTORY

Date: _____ Please circle: NEW or UPDATED **Please PRINT and COMPLETE using BLACK INK only**

LAST Name: _____ FIRST Name: _____ Middle Initial: ___ DOB: _____ Male Female

Are you allergic to any medications? No Yes Aspirin Codeine Erythromycin Penicillin Sulfa Other _____

Current Oral / Topical / Injectable Medications / None

Do you use any natural, herbal or alternative medicine products? No Yes please list _____

What is the MAIN REASON for your visit today? _____

Where is the location of the problem? _____ When did this current episode begin? _____

How long have you had this problem? Days Weeks Months Years Unknown Off and On for Years

Have you had previous treatment for this condition in the past? No Yes

Over-the-Counter _____ Rx Oral Meds _____ Rx Long-Term Meds _____
Rx Topical Meds _____ Surgery Light Therapy Laser Biopsies Blood Work

Did the treatment help? No Yes

If it is a skin lesion, is the lesion changing in Color Size Shape? _____ Slowly or Rapidly?

Skin History Do you now or have you in the past had any skin related problems? None

Abnormal Scars/ Keloids Cold Sores Herpes I or II Bleeding Disorders Slow Wound Healing Accutane Use
Acne Rosacea Folliculitis Boils Hives Dermatitis/Skin Rashes/Eczema Psoriasis Contact Dermatitis

Pre-cancerous Lesions Abnormal Moles (Dysplastic Nevi)

Skin Cancer Type and Location Please Circle Below and Write Location How Long Ago? _____

Basal Cell Carcinoma _____ Squamous Cell Carcinoma _____ Melanoma _____

Social History

Do you smoke? No Yes Do you use any recreational or IV drugs? No Yes If Yes, what? _____

For women, are you pregnant? No Yes If Yes, due date? _____ Are you breastfeeding? No Yes

What is your occupation? _____

Have you ever used a tanning booth? No Yes Are you exposed to the sun excessively? No Yes

Do you have any other MAJOR medical problems? No Yes What? _____

Do you require antibiotics prior to surgical procedures? No Yes Why? Artificial Joint or Valve or Murmur

PAST MEDICAL HISTORY do you now or in the past have a history of any of the following?

Table with 3 columns: Category, None, and List of conditions. Rows include Allergy/Immunology, Blood / Lymph, Bowel / Stomach, Ear, Nose, Throat, Eyes, General, Genital / Urinary, Heart / Circulation, Hormones, Lung, Muscle / Bone, Nerve / Neurological, Skin, Surgeries, and Family History.

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Medical History Form Completed by Patient _____ other _____ and reviewed for completion by _____ B/O Dated _____
REV.TCS 1-2010 Provider _____ Ok to Scan