CENTRE DERMATOLOGY & AESTHETIC MEDICINE
Patient Medical History Form

Patient Name _____ Date _____

Primary Care Doctor _____

Please list all medications (including vitamins and herbs) you are currently taking: _____

_____

_____

Please list any allergies to medication that you have: _____

_____

Personal Medical History

Skin Related (current or past):

	NO	YES – please explain
Melanoma		
Basal cell carcinoma		
Squamous cell carcinoma		
Actinic keratoses (Pre-skin cancers)		
Dysplastic (abnormal) moles		
Changing/Concerning moles		
Eczema (atopic dermatitis)		
Psoriasis		
Acne or Rosacea		
Other		

Other current or past health issues:

	NO	YES – please explain
General: Unexplained fatigue/fever/weight loss, cancer (not skin)		
Heme/lymph: unusual lumps, easy bruising, autoimmune disease		
Lungs: asthma, shortness of breath, COPD, chronic cough		
Neuro: headaches, dizziness, memory loss, weakness, numbness		
ENT: difficulty swallowing, mouth sores, hoarseness, hayfever		
Eyes: glaucoma, itchy/burning eyes		
Cardiovascular: cardiac disease, high blood pressure, clots		
Endocrine: thyroid disease, diabetes		
GI: bowel disease, hepatitis, liver disease		
GU: pain on urination, incontinence, genital lesions		
Musculoskeletal: arthritis, artificial joints		
Psych: depression, anxiety, other psychiatric disease		
Other		
Currently on Aspirin, Coumadin, Plavix, or other blood thinners		
Tend to bleed easily		
Allergic/Sensitive to anesthesia		
Has a pacemaker or defibrillator		
Has artificial valves or joints		
Requires antibiotics for dental work		

Please list any past surgeries: _____

(Please turn over)

Patient Medical History Form

(continued)

Family History:

	NO	YES	IN WHOM?
Melanoma			
Basal or Squamous Cell Carcinoma			
Dysplastic (abnormal) moles			
Psoriasis			
Eczema, hayfever, asthma			
Other skin issues			

Social History: Please circle your responses

Alcohol use: Daily Occasionally Never

Smoker: No Yes If yes, how often? _____

Sunscreen use of SPF #30 or higher: Daily Occasionally Never

Have you ever had blistering sunburns? No Yes

Do you spend a lot of time outdoors? No Yes If yes, which activities? _____

Marital Status: Single Married Other

Occupation: _____

For female patients who are able to get pregnant: Please circle your responses

Are you pregnant? No Yes Possibly

Are you currently breastfeeding? No Yes

Are you planning a pregnancy within 1 year? No Yes Possibly

Who referred you here today?_____

By signing below, I attest that the above information is true to the best of my knowledge.

_____

Patient/Guardian Signature