

Name \_\_\_\_\_

Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Medications** (or attach list)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medication Allergies**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Your Medical History**

Skin Cancer           **Yes / No**

Other Cancer         **Yes / No**

Hepatitis             **Yes / No**

Diabetes              **Yes / No**

High Blood pressure **Yes / No**

Heart problems      **Yes / No**

Pacemaker           **Yes / No**

Other Medical Problems:

\_\_\_\_\_

Surgeries:

\_\_\_\_\_

**Skin History**

Radiation treatments           **Yes / No**

History of blistering burns      **Yes / No**

Tanning bed use                 **Past / Present / Never**

Sunscreen user                  **Yes / No**

Eczema / Psoriasis / Acne / other skin conditions

**Family History**

Skin Cancer / Eczema

Psoriasis / Acne

None of the above

Other

Who \_\_\_\_\_

**Social History**

Occupation \_\_\_\_\_

Who do you live with?

\_\_\_\_\_

Smoker               **Yes / No**

Alcohol              **Yes / No**

**System Review** - Please circle your current symptoms

Chest pain / Poor circulation / Leg Swelling	Nasal Congestion / Difficulty Swallowing
General Health: Good / Fair / Poor	Hearing Loss / Nose Bleeds / Abdominal Pain /
Fever / Loss of appetite / Night Sweats /	Constipation / Diarrhea / Back Pain
Weakness / Weight Change	Muscle Weakness / Joint Pain / Muscle Pain
Changing lesions / Dry Skin / Itching / Rash	Dizziness / Headaches / Burning in Hands or Feet
Sores in Nose / Sores in Mouth / Dry Mouth	Change in Vision / Dry or Itchy Eyes / Anxiety
	Depression / Cough / Shortness of Breath / Wheezing

\_\_\_\_\_  
 Patient signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 MD signature

\_\_\_\_\_  
 Date