

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

General Health: Good / Fair / Poor

Fever / Loss of appetite / Night Sweats /

Weakness / Weight Change

Changing lesions / Dry Skin / Itching / Rash

Sores in Nose / Sores in Mouth / Dry Mouth

Nasal Congestion / Difficulty Swallowing

Hearing Loss / Nose Bleeds / Abdominal Pain /

Constipation / Diarrhea / Back Pain

Muscle Weakness / Joint Pain / Muscle Pain

Dizziness / Headaches / Burning in Hands or Feet

Change in Vision / Dry or Itchy Eyes / Anxiety

Depression / Cough / Shortness of Breath / Wheezing

Patient signature

Date

MD signature

Date