

Medical History

Name: _____

Date: _____

Reason for Visit: _____

Do you have or have you recently had any of the following problems?

- | | | |
|----------------------------------|-----------------------------|----------------------------|
| Y N Changing or Bleeding Moles | Y N Shortness of Breath | Y N Burning on Urination |
| Y N Skin Rash | Y N Fainting/Dizzy Spells | Y N Frequency of Urination |
| Y N Hives | Y N High Blood Pressure | Y N Diabetes |
| Y N Seasonal Allergies/Hay Fever | Y N Chest Pain | Y N Hypo/Hyper Thyroid |
| Y N Red Irritated Eyes | Y N Pacemaker | Y N Swollen Glands |
| Y N Glaucoma | Y N Heart Valve Replacement | Y N Weight Loss/Gain |
| Y N Seizures | Y N Mitral Valve Prolapse | Y N Nausea/Vomiting |
| Y N Headaches/Migraines | Y N Heart Murmur | Y N Diarrhea |
| Y N Fever | Y N Irregular Heart Beat | Y N Discoloration of Stool |
| Y N Sore Throat | Y N Phlebitis/Thrombosis | Y N Hepatitis |
| Y N Sinus Problems | Y N Swelling of Legs | Y N Herpes Simplex Virus |
| Y N Asthma | Y N Blood Clots | Y N HIV/AIDS |
| Y N Emphysema | | |

- | | |
|-------------------------------|---------------------------|
| Y N Do you use illicit drugs? | If yes, which ones? _____ |
| Y N Do you smoke cigarettes? | If yes, how much? _____ |
| Y N Do you drink alcohol? | If yes, how much? _____ |

Have you ever had a skin cancer, including malignant melanoma? Y N
If yes, please explain (what kind, location, method of treatment, etc.)

Has anyone in your family had a skin cancer, including malignant melanoma? Y N
If yes, what type and in whom?

Please complete the other side of this form.

Do you have a history of any specific skin disease or skin problem? Y N
If yes, please list or explain

Do you have a tendency to develop keloid or raised scars after injury or surgery? Y N

Do you bleed or bruise easily? Y N

Are you pregnant or nursing? Y N

Are you allergic to any local anesthetics? Y N

List all significant medical conditions, surgery, or injury not mentioned above with year of occurrence

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Are you allergic to latex? Y N

Do you have any drug allergies? Y N

If yes, please list drug as well as allergic reaction you experience

_____	_____
_____	_____
_____	_____

Please list all of the medications you taking. Please include prescription and over-the-counter medications as well as oral and topical medication.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Patient / Guardian Signature

Date