Patient Health History Form

Referring provider: _____

Past Medical History: Select any of the following medical conditions you currently have (please select all that apply):

No Past Medical History	COPD	Hypertension	Prostate Cancer
Anxiety	Coronary Artery Disease	HIV/AIDS	Radiation Treatment
Asthma	Depression	Hypercholesterolemia	Seizures
Atrial Fibrillation	Diabetes	Hyperthyroidism	Stroke
Bone Marrow Transplant	End Stage Renal Disease/Kidney Disease	Hypothyroidism	Other:
BPH	GERD	Leukemia	Other:
Breast Cancer	Hearing Loss	Lung Cancer	Other:
Colon Cancer	Hepatitis	Lymphoma	Other:

Past Surgical History: Select any of the surgeries that you've had (please select all that apply):

No Past Surgical History	Heart: PTCA	Prostate Biopsy
Appendix Removed	Joint Replacement, Hip/Knee (please indicate right/left/bilateral)	Prostate Cancer
Bladder Removed	Kidney Biopsy	Rectum: APR
Breast Biopsy (please indicate right/left/bilateral)	Kidney Stone Removal	Rectum: Low Anterior Resection
Breast Lumpectomy (please indicate right/left/bilateral)	Kidney Transplant	Skin: Basal Cell Cancer
Colectomy (please indicate reason)	Kidney Nephrectomy	Skin: Melanoma
Colon: Colostomy	Liver: Hepatectomy	Skin: Skin Biopsy
Gallbladder Removed	Liver Transplant	Skin: Squamous Cell Carcinoma
Heart: Biological Valve Replacement	Liver Shunt	Spleen Removed
Heart: Coronary Artery Bypass	Ovaries Removed (please indicate reason)	Testicles Removed (please indicate right/left/bilateral)
Heart: Heart Transplant	Ovaries: Tubal Ligation	Uterus: Cervical Cancer
Heart: Mechanical Valve Replacement	Pancreatectomy	Uterus: Hysterectomy (Please indicate Reason
Other:		

List all medications you are currently taking (including prescription, over-the-counter, vitamins, herbals, and topicals):

Name of Medication	Dose & Frequency	Name of Medication	Dose & Frequency
1.		4.	
2.		5.	
3.		6.	

Do you have any allergies to medications? No: ☐ **Yes:** ☐ If Yes, List type of reaction: _____

History of allergic conditions and skin disease:

No History of Allergic Conditions and/or Skin Disease	Basal Cell Skin Cancer	Psoriasis
Acne	Blistering Sunburns	Squamous Cell Skin Cancer
Actinic Keratoses	Flaking or Itchy Scalp	Other:
Asthma/Eczema/Hay Fever/Allergies	Melanoma	

Do you wear sunscreen? **No:** ☐ **Yes:** ☐ If Yes, what SPF? : _____
Do you tan in a tanning salon? **No:** ☐ **Yes:** ☐
Do you have a Family history of MELANOMA (Not the same as basal cell or squamous cell carcinomas) **No:** ☐ **Yes:** ☐
If yes, which family member? _____

Healthcare & Personal Devices:

Medical/Dental Implants:_____ Fillings:_____
Crowns/bridges: _____ Piercings:_____
Braces:_____ Stents:_____
Gold:_____ Amalgam:_____
Tattoos:_____ Other: _____

Review of Systems: Are you CURRENTLY experiencing any of the following? (please check any that you have experienced):

Problems with bleeding	Bloody Urine	Muscle weakness
Problems with healing	Blurry vision	Neck stiffness
Problems with scarring	Chest pain	Night sweats
Immunosuppression	Cough	Seizures
Changing Mole	Depression	Shortness of breath
Rash	Fever or chills	Sore throat
Abdominal pain	Headaches	Thyroid problems
Anxiety	Hay Fever	Unintentional weight loss
Bloody stool	Joint aches	Wheezing

Alerts (please check any that you have experienced):

Pacemaker	Blood thinners	-West Africa: travel or contact -Ebola Risk: Fever >= 100.4 degrees -Ebola Risk: resided or traveled to country-wide spread Ebola transmission in the last 21 days
Defibrillator	Pregnancy or planning a pregnancy	
Artificial joints within the past 2 years	Allergy to lidocaine	
Artificial heart valve	Rapid heartbeat with epinephrine	
Premedication prior to procedures	Yeast infections with antibiotics	
Allergy to adhesive	GI upset with antibiotics	
Allergy to topical antibiotic ointments	Other:	

Personal information:

Marital Status: Married: ☐ Single: ☐ Divorced: ☐ Separated: ☐ Widow: ☐
Number of Children:_____ Boys: _____ Girls: _____ Do you have pets?: **No:** ☐ **Yes:** ☐ If Yes, type: _____

Occupation:_____ Job description: _____
Employer:_____ Since (date): _____
Exposure to health hazards at work?: **No:** ☐ **Yes:** ☐ If Yes, type:_____
Do you smoke or use tobacco products? **No:** ☐ **Yes:** ☐ If Yes, type: _____How long? ____Packs or tins per day ____

Reason for today's visit: _____

Current area(s) affected:

☐ Scalp ☐ Palm ☐ Chest
☐ Face ☐ Fingertips ☐ Back
☐ Eyelids ☐ Between fingers ☐ Genitals
☐ Top of hand ☐ Arms ☐ Legs
☐ Feet

Symptoms: Itching ☐ Pain ☐ Peeling ☐ Burning ☐ Cracking ☐ Redness ☐
When did you first notice this problem?_____ Continuous ☐ Intermittent ☐
History of biopsies? _____ Explain: _____
Do symptoms improve during weekends/holidays/vacations? **No:** ☐ **Yes:** ☐
Loss of work?: **No:** ☐ **Yes:** ☐ If Yes, what dates: _____

Signature: Completed by: Patient ☐ Parent/guardian ☐ Nurse ☐

Patient/Authorized signature:_____ Date:_____