

Medical Information

Name: _____

Date of visit: _____

Reason for visit: _____

Past Medical History

Basal Cell Carcinoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seasonal Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Squamous Cell Carcinoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Melanoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Atopic Dermatitis (Eczema)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other: _____

Family History

Basal Cell Carcinoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seasonal Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Squamous Cell Carcinoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Melanoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Atopic Dermatitis (Eczema)	<input type="checkbox"/> Yes <input type="checkbox"/> N

Other: _____

Social History

Occupation: _____ Tobacco Yes No Alcohol Yes No Occasional

Other: _____

Review of Systems

(please describe any current problems in the following body systems; describe positive responses on the right)

Constitutional (fever, unintentional weight loss)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Eyes (discharge, dry eyes)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Ears, Nose, Mouth, Throat (any problems?)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cardiovascular (chest pain, palpitations)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Respiratory (wheezing, shortness of breath)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Gastrointestinal (diarrhea, nausea, vomiting)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Genitourinary (urination, pelvic cramps, discharge)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Musculoskeletal (joint pain, muscle aches)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Neurological (damaged nerves, speech problems)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Psychiatric (depression, anxiety)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Endocrine (diabetes, thyroid problems)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hematologic/lymphatic (anemia, leg swelling)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Allergic/Immunologic (any problems)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Medical Information

Current Skin Complaints

- Changing moles or skin lesions (Where?) _____
- Rash (Where?) _____
(Describe) _____
- Warts (Where?) _____
- Acne (Where?) _____
- Psoriasis (Where?) _____
- Cosmetic concerns (Describe) _____

- Other skin issue (Describe) _____

Medications

(List all current medications including creams, over-the-counter meds, vitamins, herbal supplements, suppositories, eye drops, etc)

(If you are being evaluated for a rash or skin allergy, list all other medications taken at any time during the past 6 months)

Medication Allergies _____

No known drug allergies

Signed _____ Date: _____