**Medical History Form** Appointment Date: ______________________

Mr. /Mrs. /Ms. /Dr. (Circle One)

Last Name: ______________________ First Name: ______________________ MI: ______

Date of Birth: (MM/DD/YYYY) ____________ Sex: M / F **(Circle)** Occupation: ________________

Marital Status: **(Circle One)** Married Single Divorced Widowed Other: ____________

Preferred Pharmacy: ______________________ Cross Streets: ______________________

**Yes, No** Do you have a separate card for prescription benefits?
**If Yes, Please give the benefits card to the patient service representative when you check-in.**

Reason(s) for today's visit: __________________________________________

Primary Care Provider: ______________________ Referring Provider: ______________________

---

**Please write in an answer or circle yes or no to all the questions below.**

## Past Medical History:

Have you been previously diagnosed with any of the following? **(Circle all that apply or circle none.)**

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation/Irregular Heartbeat
- Benign Prostatic Hyperplasia
- Bone Marrow Transplant
- Breast Cancer
- Bleeding Problems
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End-Stage Renal Failure
- Gastro Reflux Disease
- Hearing Loss
- Hepatitis
- High Blood Pressure
- HIV/Aids
- High Cholesterol
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- **NONE**

List any other diseases or conditions: __________________________________________

List any surgical procedures you have had in the last **24** months:

__________________________________________

**Yes, No** Do you have and Advance Care Plan? If **YES**, please list the person's name and contact number below.

Name: ______________________ Contact Number: ______________

---

## Skin Disease History: (Circle all that apply or circle none.)

- Acne
- Actinic Keratosis/Precancerous Lesions
- Atypical Moles (**Only** if diagnosed by a physician)
- Basal Cell Carcinoma/Skin Cancer
- Blistering Sunburns
- Dry Skin
- Flaking or Itchy Scalp
- Melanoma
- Psoriasis
- Squamous Cell Carcinoma/Skin Cancer
- **NONE**
- Other: ____________________

Appointment Date: ____________________

Last Name: ______________________________________ First Name: ________________________________MI: ________

Date of Birth: (MM/DD/YY):___________________

---

**Yes** **No** Do you wear sunscreen? **If so, what SPF?** _________________

**Yes,** **No** Are you currently using a tanning bed?

---

## Family Medical History:

**Yes** **No** Do you have a family history of MELANOMA?

If yes, which relatives? **(Circle all that apply.)**

Mother Father Sister Brother Daughter Son Grandmother Grandfather Nephew Niece Other

## Medications:

List all medications you are currently taking. Include prescriptions over the counter medications, vitamins, and herbals. Use additional paper if needed. Please notify our office if you decline to have your medication list imported from participating pharmacies. **PLEASE GIVE YOUR PHARMACY INSURANCE CARD TO THE FRONT OFFICE AT CHECK IN TO HELP FACILITATE YOUR MEDICATIONS ARE AUTHORIZED PROPERLY.**

| NAME | STRENGTH/AMOUNT | DOSE (Tablet, Capsule, etc.) | FREQUENCY |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Allergies:

**Yes** **No** Are you allergic to any medications?

If **yes**, list all medications: ________________________________________________________________

## Social History:

**Yes** **No** Are you a current smoker? Cigarette Smoker / Cigar Smoker / Both **(Circle one.)**

Total Years Smoking: _________________ If yes, how many packs per day? _________________________

Yes No Are you a former smoker?

Total Years Smoked: __________________ If yes, how many packs did you smoke per day?

---

Yes No Not Sure Do you develop Keloid (raised) scars after surgery?

**Yes** **No** **Not Sure** Do you bleed easily?

**Have you had previous problems with any of the following? (Circle all that apply or circle none.)**

Allergic Reaction to Adhesive Bandages
Allergic Reaction to Topical Antibiotic Ointments
Artificial Heart Valve
Artificial Joints within the Last 2 Years
Blood Thinners
**OTHER:**________________________________
Defibrillator
MRSA
Pacemaker
Premedication Before Procedures
Rapid Heartbeat with Epinephrine/Local Anesthesia
**NONE**