New Patient Medical History Form

Date (month/day/year): _____ / _____ / ______

Last name: ____________________________ First name: ____________________________

Date of Birth (month/day/year): _____/_____/_____

Reason for today's visit: ____

Have you been previously diagnosed with any of the following: (Circle all that apply)

Anxiety /Depression / Arthritis / Asthma / Atrial Fibrillation (Irregular Heartbeat)

BPH (Enlarged Prostate) / Bone Marrow Transplant / Breast Cancer / Colon Cancer

COPD / Coronary Artery Disease / Heart Valve Replacement / Diabetes

Kidney Disease / GERD (Acid Reflux) / Hearing Loss / Hepatitis / or other Liver Disease

Hypertension / HIV/AIDS / High Cholesterol / Leukemia / Lung Cancer / Lymphoma

Prostate Cancer / Radiation Treatment / Seizures / Stroke / Joint Replacement

List any other past or present diseases or conditions:

____

____

List any past surgical procedures and year:

____

____

Have you had any of the following skin conditions:

□ Acne □ Actinic Keratosis □ Blistering Sunburns □ Eczema □ Precancerous Moles □ Psorasis

□ Other ____

____

Have you ever had skin cancer? □ Yes □ No

If yes: □ Basal Cell Carcinoma □ Squamous Cell Carcinoma □ Melanoma □ Not sure of name

If you know the dates of your skin cancer treatments/surgeries please list:

____

____

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Has anyone in your family been diagnosed with melanoma?
□ Yes □ No Relationship/s ____

Do you wear sunscreen? □ Yes □ No If yes, what SPF?_______

Do you currently or have you ever tanned at a tanning salon? □ Yes □ No

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

__________________________ ________________________ ___________________________

__________________________ ________________________ ___________________________

__________________________ ________________________ ___________________________

Are you allergic to any medications? □ YES □ NO If yes, list below:

__________________________ ________________________ ___________________________

Do you drink alcohol? □ Yes □ No If yes, how many drinks per day? _________

Do you use IV drugs? □ Yes □ No If yes, what? _______________________ How often? ___________

Please circle all that apply: Current every day smoker / Occasional smoker / Former smoker / Never

Do you currently or have you ever used smokeless tobacco? □ Yes □ No

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

Do you have problems with healing? □ Yes □ No

Do you bleed easily? □ Yes □ No

Have you been previously diagnosed with any of the following: (Circle all that apply)

Allergy to adhesive / Allergy to lidocaine / Allergy to topical antibiotic ointments / Pacemaker

Artificial heart valve / Artificial joints within past two years / Blood thinners / Defibrillator / MRSA

Premedication prior to procedures / Rapid heartbeat with epinephrine

Have you had a reaction to local anesthesia (Novacaine) at a dermatology or dental visit? □ Yes □ No

(Women) Could you be pregnant or are you trying to become pregnant soon? □ Yes □ No

If yes, what is your due date: ___/___/___

(Women) Do you get yeast infections with antibiotic use? □ Yes □ No

What is your occupation? ____

Hobbies? ____