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# SOUTHERN DERMATOLOGY

SKIN CANCER CENTER  
SKIN RENEWAL CENTER

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## MEDICAL HISTORY FORM

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**Patient Name:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Chart #: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone #: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Care Doctor Name & Number: \_\_\_\_\_

Referring Doctor Name & Number: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Gender:  Female  Male

Language:  English  Spanish  Other:

Race:  White  Asian  Black/African American  Other:

Ethnicity:  Hispanic/Latino  Non Hispanic/Latino  Other:

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**Medications:** (Please Enter All Current Medications)

Medication Name	Strength (mg)	Route (oral, topical)	Dose (# of pills taken)	Frequency

**Allergies:** (Please Enter All Allergies) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICAL HISTORY FORM (cont)**

**PAST MEDICAL HISTORY**

(Please Select All That Apply)

- Anxiety
- Arthritis
- Artificial Joints
- Asthma
- Atrial Fibrillation
- Bone Marrow Transplantation
- BPH (Benign Prostatic Hyperplasia)
- Breast Cancer
- Colon Cancer
- COPD (Emphysema)
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD (Acid Reflux)
- Hearing Loss
- Hepatitis
- High Blood Pressure
- High Cholesterol
- HIV/AIDS
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- Other: \_\_\_\_\_
- None

**PAST SURGICAL HISTORY**

(Please Select All That Apply)

- Appendix Removed
- Bladder Removed
- Mastectomy (Right, Left, Both)
- Lumpectomy (Right, Left, Both)
- Breast Biopsy (Right, Left, Both)
- Breast Reduction
- Breast Implants
- Colon Cancer Resection
- Diverticulitis
- Inflammatory Bowel Disease
- Gallbladder Removed
- Coronary Artery Bypass
- PTCA
- Mechanical Valve Replacement
- Biological Valve Replacement
- Heart Transplant
- Joint Replacement, Knee (Right, Left, Both)
- Joint Replacement, Hip (Right, Left, Both)
- Kidney Biopsy
- Kidney Removed (Right, Left)
- Kidney Stone Removal
- Kidney Transplant
- Ovaries Removed: Endometriosis
- Ovaries Removed: Cyst
- Ovaries Removed: Ovarian Cancer
- Prostate Removed: Prostate Cancer
- Prostate Biopsy
- TURP
- Skin Biopsy
- Basal Cell Cancer Surgery
- Squamous Cell Carcinoma Surgery
- Melanoma Surgery
- Spleen Removed
- Testicles Removed (Right, Left, Both)
- Hysterectomy: Fibroids
- Hysterectomy: Uterine Cancer
- Other: \_\_\_\_\_
- None

**SKIN DISEASE HISTORY**

(Please Select All That Apply)

- Acne
- Actinic Keratoses
- Asthma
- Basal Cell Skin Cancer
- Blistering Sunburns
- Cold Sores/HSV
- Dry Skin
- Eczema
- Flaking or Itchy Scalp
- Hay Fever/Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Skin Cancer
- Other: \_\_\_\_\_
- None

Do you have a family history of Melanoma?       Yes       No

If yes, which relative(s)?

Any other family history: \_\_\_\_\_

\_\_\_\_\_

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**MEDICAL HISTORY FORM (cont)**

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**SOCIAL HISTORY**

(Please Select One in Each Section)

Smoking Status:     Daily smoker     Occasional smoker     Former smoker     Never smoked  
Alcohol Use:         Never         Drink less than 1 per day     Drink 1-2 per day     Drink 3 or more per day

**REVIEW OF SYSTEMS**

(Have you had any of the following in the last 30 days?)

Problems with Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Problems with Healing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Problems with Scarring	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Immunosuppression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fever or Chills	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Night Sweats	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unintentional Weight Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sore Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blurry Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abdominal Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bloody Stool	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bloody Urine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Joint Aches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Muscle Weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neck Stiffness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wheezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergy to Adhesive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergy to Lidocaine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergy to Topical Antibiotic Ointments	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Joints within past 2 years	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Thinners	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Defibrillator	<input type="checkbox"/> Yes	<input type="checkbox"/> No
MRSA	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Premedication prior to Procedures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rapid Heart Beat with Epinephrine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pregnancy or Planning a Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No