

Please complete the following medical history form

Name _____ Date _____

Age ____ Sex ____ Referring Doctor _____

Reason for today's visit: History of today's problem(s):

Skin areas involved: _____ How long has the problem been present? _____

Was a biopsy done? No Yes biopsy done by referring MD Other
Was there any previous treatment? No Yes If yes, what was done and when?

Check all that apply regarding today's problem: Change in: Size Color Bleeding Elevation
 Hardness

Please list all medications: (Include vitamins, herbs, supplements) _____

Medication: **ALLERGIES:** None List: _____

Check *ALL* that apply regarding your overall health *and add any other medical problems:*

CARDIOVASCULAR

- normal
- artificial heart valve
- pacemaker
- high blood pressure
- heart attack when?
- high cholesterol

- bypass or other surgery
- Mitral valve prolapse
- other heart problem

GASTROINTESTINAL

- normal
- stomach ulcer
- colitis
- irritable bowel syndrome

NEUROLOGICAL

- normal
- stroke
- seizure disorder
- Alzheimer's

**PSYCHIATRIC
MUSCULOSKELETAL**

- normal
- depression
- anxiety disorder
- other:

BLOOD / LYMPH

- normal
- anemia
- enlarged lymph glands
- bleeding problems

RESPIRATORY

- normal
- emphysema

ENDOCRINE

- normal
- diabetes
- thyroid problem

SKIN

- normal
- keloids
- poor/slow healing

GENERAL

- normal
- fever weight loss

INFECTIONS

- none
- hepatitis
- HIV or AIDS
- TB (tuberculosis)

- normal
- arthritis
- artificial joint
- fibromyalgia

HEAD / NECK

- normal
- hearing aid
- glaucoma
- plastic surgery

OTHER MEDICAL PROBLEMS: _____

Previous skin cancer? _____

MAJOR ILLNESS OR HOSPITALIZATIONS: None List: _____

FAMILY HISTORY: melanoma other skin cancer (basal cell or squamous cell)
 bleeding problems other major medical problems:

Occupation: _____ Marital Status: S M D W

- Do you wear: dentures glasses contact lenses
- Smoking: no former yes; how many packs/day? _____
- Alcohol: no social drinking only
- Alcohol or drug problems/addictions: no describe: _____