MEDICAL HISTORY FORM

Dermatology & Skin Surgery Center

210 Village Center Pkwy - Stockbridge, GA. 30281
(770) 474-5952

NAME: ______________________________ **DATE OF BIRTH:** __________ **AGE:** ____

SEX: ____ **HEIGHT:** _____ **WEIGHT:** _____ **EMAIL:** ____________________________

PHARMACY: ____________________________ **REFERRED BY:** __________________

REASON FOR TODAY'S VISIT: ____

Skin areas involved: ____

How long has the problem been present? __________________________________

Has a skin biopsy been done? ☐ No ☐ Yes - Result?______________________________

Was there any previous treatment? ☐ No ☐ Yes - What? __________________________

LIST ALL MEDICATIONS (including vitamins, herbs, supplements) **OR BRING SEPARATE LIST:**

____

____

DRUG ALLERGIES: ____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING? (Circle all that apply.)

Anxiety

Arthritis

Asthma

Atrial fibrillation (irregular heartbeat/arrhythmia)

Benign prostatic hyperplasia (enlarged prostate)

Cataracts

Cerebrovascular accident (stroke)

Chronic obstructive lung disease (COPD)

Coronary artery disease

Depression

Diabetes ☐ Type I ☐ Type II

End-stage kidney disease (ESRD)

Gastroesophageal reflux disease (GERD)

Glaucoma

Hypertension (high blood pressure)

Other ______________________________

Hearing loss

Human immunodeficiency virus (HIV/AIDS)

High cholesterol

Hyperthyroidism (high thyroid function)

Hypothyroidism (low thyroid function)

Inflammatory disease of liver (hepatitis)

Leukemia

Lymphoma

Lung cancer

Breast cancer

Colon cancer

Prostate cancer

Radiation therapy

Seasonal allergies

Transplantation of bone marrow

None _____

(PLEASE TURN PAGE OVER TO COMPLETE)

Name: ________________________

PAST SURGICAL HISTORY (CIRCLE ALL THAT APPLY):

Appendectomy (appendix removed)
Bilateral tubal ligation
Cholecystectomy (gallbladder removed)
Colectomy (part of colon removed)
Coronary angioplasty (balloon angioplasty)
Coronary artery bypass graft
Coronary artery stent
Hysterectomy
Joint replacement - joint & year: _____________
Lumpectomy - circle: left / right / both
Mastectomy - circle: left / right / both
Mechanical heart valve replacement
Prosthetic heart valve replacement
Solid organ transplant - organ: ______________
Splenectomy (spleen removed)
None _____
Other ____

CIRCLE ANY SKIN OR SKIN-RELATED CONDITIONS YOU HAVE HAD:

Acne
Actinic keratosis (precancer)
Basal cell carcinoma (BCC)
Biopsy of skin – result: ____________
Contact dermatitis (rash) due to poison ivy
Dry skin
Dysplastic nevus (precancerous mole by biopsy)
Eczema
Melanoma - location & year: ___________
Psoriasis
Squamous cell carcinoma (SCC)
Sunburns (blistering)
Other ____

Do you wear sunscreen? ☐ No ☐ Yes – SPF: ______

Have you tanned at a tanning salon or in a tanning bed? ☐ Past ☐ Present ☐ Never

Do you have a **family history of melanoma**? ☐ No ☐ Yes: Which relative(s)? ______________

Do you have a **family history of any other skin cancers**? ☐ No ☐ Yes

SOCIAL HISTORY

Occupation: ____________________________

Smoking: ☐ Daily
☐ Occasionally
☐ In the past
☐ Never

Alcohol (Drinks per Day): _____________________

IV Drug Use: ☐ Past ☐ Present ☐ Never

Other Drug Use: ______________________________

Sexual Partners: ☐ None ☐ One ☐ Multiple

(For Women) Date of Last Period: _______________

Name: ______________________

ARE YOU *CURRENTLY* EXPERIENCING ANY OF THESE SYMPTOMS? (Circle all that apply.)

Changing mole
Rash
Abdominal pain
Bloody stool
Bloody urine
Blurry vision
Cough
Depression
Fevers or chills
Headaches
Joint aches
Muscle weakness
Drenching night sweats
Seizures
Shortness of breath
Unintentional weight loss
Wheezing
Unwanted hair growth
Itch
Diarrhea
Irregular menstrual periods
Mouth sores

DO YOU HAVE ANY OF THE FOLLOWING? (Circle all that apply.)

Problems with bleeding
Problems with healing
Problems with scarring (keloid or hypertrophy)
Pacemaker
Defibrillator
Artificial joint(s) within the last 2 years
Artificial heart valve
Need premedication prior to procedures – which meds? ________________________
Allergy to adhesive
Allergy to antibiotic ointments or creams
Taking blood thinners (including aspirin)
Pregnant currently, trying to conceive/planning a pregnancy, or breastfeeding currently
Allergy to lidocaine
Rapid heartbeat with epinephrine
Yeast infection with antibiotics
Immunosuppression (due to marrow or organ transplantation, chemotherapy, biologics, etc.)