Alpine Dermatology Associates, P.L.L.C.

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MEDICAL HISTORY

Primary Doctor _____

Referred by _____

Patient Name _____ Date _____

Are you allergic to any medications? Yes/No If yes, please list:

1. 3.
2. 4.

LIST ALL MEDICATIONS (PRESCRIPTION, OVER THE COUNTER, HERBAL) YOU ARE CURRENTLY TAKING:

1. 4.
2. 5.
3. 6.

HISTORY OF MEDICAL PROBLEMS

Do you have or have you ever had problems with…Circle (Y)es or (N)o:

Systemic

Diabetes .....Y N
Thyroid .....Y N
Kidney/urinary tract .....Y N
Stomach .....Y N
Bowels/gall bladder .....Y N
Liver/spleen/hepatitis .....Y N
Allergies/hay fever/sinus .....Y N
Seizures/epilepsy.....Y N
Fainting .....Y N
Glaucoma/eyes .....Y N
Alcoholism.....Y N
AIDS exposure.....Y N
Phlebitis .....Y N
Arthritis.....Y N

Lungs

Asthma .....Y N
Emphysema .....Y N
Bronchitis.....Y N
Morning cough .....Y N
Chronic cough .....Y N
TB/clots in lungs.....Y N

Vascular

High blood pressure.....Y N
Chest pain.....Y N
Heart attack.....Y N
Heart murmur.....Y N
Irregular/fast heart beat .....Y N
Pacemaker.....Y N

Other: _____

FAMILY HISTORY OF MEDICAL DISEASES

Cancer.....Y N
High blood pressure.....Y N
Heart disease.....Y N
Stroke.....Y N
Arthritis.....Y N
Diabetes.....Y N
Allergy/hay fever/sinus.....Y N
Family history of skin diseases.....Y N

Other: _____

LIST PAST SURGERIES AND APPROXIMATE TIME/AGE

_____

_____

PLEASE ANSWER THE FOLLOWING

1. Do you smoke/chew tobacco?.....Y N How much?_____
2. Do you use recreational drugs?.....Y N Which drug(s)? _____
3. Do you bleed easily/aspirin.....Y N
4. Any artificial joints? .....Y N Where? _____
5. **Women:**

   Are you pregnant?.....Y N Due date _____
   Breast feeding?.....Y N
   Are you on the Pill? .....Y N Depoprovera shots? Y N Estrogen? Y N
   Progesterone? .....Y N

SKIN HISTORY

1. Where did you grow up?_____ Were you a lifeguard? Y N
2. How many blistering sunburns did you get before age 21? ____
3. Anyone in your family have skin cancer?...Y N
   - Basal cell.....Y N
   - Squamous cell.....Y N
   - Melanoma .....Y N
   - Pre cancer.....Y N
4. Have <u>you</u> had skin cancers? .....Y N
   - Basal cell.....Y N
   - Squamous cell.....Y N
   - Melanoma .....Y N
   - Pre cancer.....Y N
5. Do you have a history of skin disease?.....Y N
6. Any other diseases or conditions we should know about? Please describe:

   _____
7. Do you use sunscreen regularly?.....Y N
8. Any surgery done in the past 6 months? ....Y N If yes, what and when:

   _____
9. What is your occupation? _____
10. What are your hobbies?_____

Completed by: ____Patient ____Other relationship _____ ____Medical assistant

Reviewed by: _____ Date: _____