complete skin md

Patient History

Name: _____ **Date:** _____
DOB: _____

PAST MEDICAL HISTORY

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ BPH (Benign Prostatic Hyperplasia)
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ BRCA positive
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Diabetes ☐ Type I ☐ Type II
- ☐ End Stage Renal Disease
- ☐ GERD (Acid reflux)
- ☐ Hearing Loss
- ☐ Hepatitis A B C Unknown
- ☐ Herpes Simplex (Fever Blisters)
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ IBD (Crohn's, Colitis)
- ☐ IBS
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Migraine headaches
- ☐ Organ Transplant
  Please specify _____
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Pulmonary Embolus
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement
- ☐ None
- ☐ Other Please specify _____

Medications: (Please enter all current medications)

_____

_____

Allergies: (Please enter all allergies and reaction(s))

_____

_____

☐ No known allergies to medication

Do you require pre-medication with an antibiotic prior to routine dental work (i.e. cleaning)? ☐ Y ☐ N If Yes, Indication:_____
Do you have a Pacemaker? ☐ Y ☐ N
Do you have a Defibrillator? ☐ Y ☐ N

PAST SURGICAL HISTORY

- ☐ Angioplasty
- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Coronary Artery Bypass
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Lumpectomy
- ☐ Breast Biopsy
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Cesarean Section
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee
- ☐ Joint Replacement, Hip
- ☐ Joint Replacement Date Specify date
- ☐ 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
- ☐ Spleen Removed
- ☐ Testicles Removed
- ☐ Valve Replacement
  - Type: Specify type
  - Date:
- ☐ None
- ☐ Other Please specify _____

SKIN DISEASE HISTORY

- ☐ Acne
- ☐ Actinic Keratoses (precancers)
- ☐ Basal Cell Carcinoma
- ☐ Blistering Sunburns
- ☐ Eczema
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Merkel Cell Carcinoma
- ☐ Mohs Surgery
- ☐ MRSA
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
- ☐ None
- ☐ Other

Please specify _____

Are you currently using any medications prescribed for your skin: ☐ Y ☐ N
If yes, please specify:_____

Do you wear Sunscreen? ☐ Y ☐ N If yes, what SPF? _____
Have you ever used a tanning salon? ☐ Y ☐ No Currently? ☐ Y ☐ N
Have you had blistering sunburns? ☐ Y ☐ N
Do you react to anesthesia? ☐ Y ☐ N
Do you react to bandages/adhesives? ☐ Y ☐ N
Do you heal with thick (keloid) scars? ☐ Y ☐ N
Do you have a family history of Melanoma? ☐ Y ☐ N
If yes, which relative(s)? Please specify _____

Do you have a family history of Nonmelanoma Skin Cancer? ☐Y ☐N
If yes, which relative(s)? _____
Any other family history of cancer:
_____

Mother: ☐Alive ☐Deceased Age _____ Father: ☐Alive ☐Deceased Age _____

Are you pregnant? ☐Y ☐N Are you nursing? ☐Y ☐N
Number of Children: _____ Age(s): _____

SOCIAL HISTORY

Cigarette Smoking: Please specify

Alcohol Use: Please specify

Language: Please specify

Race: Please specify

How often do you exercise? Please specify

What is your caffeine use? Please specify

Occupation and Workplace: _____

Hobbies: _____

Place of Residence: _____