

NORTHWEST DERMATOLOGY & SKIN CANCER CLINIC

MEDICAL HISTORY

Patient _____ Birth Date _____ Date _____

Primary Physician _____ Specialty Physicians _____

Preferred Pharmacy _____

Reason for today's visit _____

Allergies YES ___ NO ___ If yes list below:

1. _____ 2. _____ 3. _____

Medications (including prescriptions, over-the-counter, vitamins, and herbals)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

Medical Conditions and Cancer

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Surgical History (Type of surgery and year)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Please check all that apply

	YES	NO		YES	NO
<i>General (current):</i>					
Fever	___	___	Dialysis	___	___
Chills	___	___	Infertility	___	___
Weight Change	___	___	<i>Hematology/Oncology:</i>		
Excessive Sweating	___	___	Easy Bruising	___	___
<i>Cardiopulmonary:</i>					
Heart Attack	___	___	Lymph Node Swelling	___	___
High Cholesterol	___	___	Recurrent Infections	___	___
High Blood Pressure	___	___	<i>Musculoskeletal:</i>		
Blood Clots	___	___	Osteoarthritis	___	___
Pacemaker	___	___	Rheumatoid arthritis	___	___
Shortness of Breath	___	___	Joint Replacement	___	___
Asthma	___	___	in past 6 months	___	___
Seasonal Allergies	___	___	<i>Neurological:</i>		
<i>Gastrointestinal:</i>					
Reflux	___	___	Seizures	___	___
Nausea/Vomiting	___	___	Numbness	___	___
Crohns/Colitis	___	___	<i>Psychiatric:</i>		
<i>Endocrine:</i>					
Thyroid Dysfunction	___	___	Depression	___	___
Diabetes	___	___	Anxiety	___	___
			ADHD/ADD	___	___
			Obsessive/Compulsive	___	___

CONTINUE (OVER)

Skin

Have you ever had skin cancer YES ___ NO ___
 Has anyone in your family had skin cancer YES ___ NO ___
 Do you have a history of any specific skin diseases YES ___ NO ___
 Have you had radiation treatment YES ___ NO ___
 Do you take blood thinners (Aspirin, Coumadin, Plavix) YES ___ NO ___

Most recent INR _____ Date _____

Do you develop skin rashes in reaction to:

Medications ___ Food ___ Bandages ___ Neosporin ___ Other ___

Social History

Do you drink alcohol YES ___ NO ___ _____ drinks per week
 Do you smoke YES ___ NO ___ _____ packs per week
 Do you use recreational drugs YES ___ NO ___ what? _____
 Have you had or have you been exposed to HIV/AIDS YES ___ NO ___
 Have you had or have you been exposed to Hepatitis YES ___ NO ___ Type: A B C

Occupation _____

Hobbies _____

Women, are you pregnant? YES ___ NO ___ / /
 Due Date

Completed by: Patient/Parent _____ / /
 Signature Date

Reviewed by: _____ / /
 Medical Assistant Date

_____ / /
 Medical Provider Date