

# Patient Medical History Record

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Date (mm/dd/yy) \_\_\_\_\_ Referred by: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

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Patient's name: \_\_\_\_\_ sex: \_\_\_\_\_ birthdate: \_\_\_\_\_ age: \_\_\_\_\_

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Address: \_\_\_\_\_ home phone: \_\_\_\_\_  
work phone: \_\_\_\_\_

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Please answer the following questions regarding your medical status and history. **Use the back of the page if necessary for explanations.**

- 1) Have you ever been treated for any medical conditions (diabetes, high blood pressure, arthritis, thyroid, etc.)?  
 yes  no If yes, please explain: \_\_\_\_\_
- 2) Have you ever had any skin disease or problems?  
 yes  no If yes, please explain: \_\_\_\_\_
- 3) Have you used any prescription creams or topical preparations in the last 2 months?  
 yes  no If yes, please explain: \_\_\_\_\_
- 4) Have you had any surgery in the last 5 years?  
 yes  no If yes, please provide date and reason \_\_\_\_\_
- 5) Have you ever been hospitalized?  
 yes  no If yes, please provide date and reason \_\_\_\_\_
- 6) Do you take any medications?  
 yes  no If yes, please list \_\_\_\_\_
- 7) Do you have any drug or food allergies?  
 yes  no If yes, please list \_\_\_\_\_
- 8) Do you have any problems with anesthesia?  
 yes  no If yes, please explain \_\_\_\_\_
- 9) Have you been tested for HIV?  yes  no If yes, what were results?  positive  negative
- 10) Do you have a history of hepatitis?  yes  no If yes, what type?  A  B  C
- 11) Do you have any bleeding problems?  
 yes  no If yes, please explain \_\_\_\_\_

## Review of Systems (circle any problems you **currently** have)

General: fever, weight loss, weight gain, fatigue, weakness, heat intolerance, cold intolerance, always thirsty, fainting

Eye: double vision, blurred vision, eyepain

Ear Nose Throat: dizziness, vertigo, hearing loss, sinus problems, sore throat, ringing in ears, nosebleeds, trouble swallowing, dry mouth, swollen lymph nodes

Cardiovascular: chest pain, irregular heart beats, rapid heartbeats, slow heart rate, anemia

Respiratory: shortness of breath, cough, coughing up blood, coughing up sputum, pain when breathing, asthma

Gastrointestinal: heartburn, abdominal pain, diarrhea, nausea, vomiting, blood in stool

Urinary: painful urination, blood in urine, frequent urination, kidney stones

Skin: dryness, excessive sweating, hair loss, hair growth, acne, rashes, night sweats

Musculoskeletal: muscle aches, joint pain, swollen joints, bone pain

Neurologic: numbness, weakness, headaches, paralysis, slurred speech

Psychiatric: depression, anxiety, obsessive compulsive disorder

## Family and Social History

Do any diseases run in your family? (melanoma, skin cancer, other cancer, diabetes, high blood pressure?)

yes  no If yes, please explain \_\_\_\_\_

Smoke cigarettes?  yes (packs per day: \_\_\_\_\_)  no Drink alcohol?  yes  no How much? \_\_\_\_\_

Had blistering sunburns?  yes  no Do you use sunscreen?  yes  no Commercial tanning?  yes  no

Outdoor occupation?  yes  no If yes, list: \_\_\_\_\_

Current occupation: \_\_\_\_\_

Have you ever had a skin cancer?  yes  no If yes, what type?  basal cell  squamous cell  melanoma

Please feel free to add any other comments on the back of this form. Indicate if there are:  comments on back