

Heartland Dermatology

Patient Medical History Record

Date (mm/dd/yy)

Referred by:

Primary Care Physician:

Patient's name:

sex:

birthdate:

age:

Address:

home phone:

work phone:

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 had any skin disease or problems?		Past Medical Problems:
2) Have you used any prescription creams or topical preparations in the last 2 months?		
3) Have you had any surgery in the last 5 years?		
4) Have you ever been hospitalized?		Medications:
5) Do you take any supplements or herbal remedies?		
6) Do you have any problems with anesthesia?		
7) Have you been tested for HIV?		
8) Have you had hepatitis?		Allergies:
9) Do you have any bleeding problems?		

Review of Systems (check off the items 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, other

Family and Social History

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

Smoke cigarettes?

Drink alcohol?

Had blistering sunburns?

Do you use sunscreen?

Commercial tanning?

Ever had an Outdoor occupation?

Current occupation

Have you ever had a skin cancer? (if yes, specify 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