

Medical History Form

Last Name _____ First Name _____ MI _____ Date _____ DOB _____

Past Medical History/ Review of Symptoms (Do you currently have or have you ever had any of the following - GIVE DETAILS)

FILL OUT COMPLETELY IN BLACK PEN. IF NO PROBLEMS IN A PARTICULAR SYSTEM, CHECK NONE.

Reason for visit: _____

<p>SKIN</p> <input type="checkbox"/> none <input type="checkbox"/> precancer (actinic keratosis) <input type="checkbox"/> basal cell carcinoma <input type="checkbox"/> squamous cell carcinoma <input type="checkbox"/> melanoma <input type="checkbox"/> abnormal scarring/keloids <input type="checkbox"/> dysplastic moles <input type="checkbox"/> cold sores <input type="checkbox"/> other _____	<p>MUSCULOSKELETAL</p> <input type="checkbox"/> none <input type="checkbox"/> MS <input type="checkbox"/> arthritis <input type="checkbox"/> muscle weakness <input type="checkbox"/> fibromyalgia <input type="checkbox"/> artificial joints <input type="checkbox"/> other _____	<p>NEUROLOGICAL</p> <input type="checkbox"/> none <input type="checkbox"/> seizure (epilepsy) <input type="checkbox"/> neuralgia/nerve pain <input type="checkbox"/> numbness/tingling <input type="checkbox"/> stroke <input type="checkbox"/> other _____	<p>CARDIOVASCULAR</p> <input type="checkbox"/> none <input type="checkbox"/> chest pain <input type="checkbox"/> heart attack <input type="checkbox"/> pacemaker <input type="checkbox"/> heart valve problem <input type="checkbox"/> high blood pressure <input type="checkbox"/> other _____
<p>RESPIRATORY</p> <input type="checkbox"/> none <input type="checkbox"/> asthma <input type="checkbox"/> emphysema <input type="checkbox"/> cough <input type="checkbox"/> other _____	<p>GASTROINTESTINAL</p> <input type="checkbox"/> none <input type="checkbox"/> stomach ulcer <input type="checkbox"/> colitis (ulcerative/chronic) <input type="checkbox"/> liver problems <input type="checkbox"/> other _____	<p>HEMATOLOGIC/LYMPHATIC</p> <input type="checkbox"/> none <input type="checkbox"/> anemia <input type="checkbox"/> bleeding problems <input type="checkbox"/> cancer/enlarged lymph nodes <input type="checkbox"/> other _____	<p>EYE/EAR/NOSE/THROAT</p> <input type="checkbox"/> none <input type="checkbox"/> glaucoma <input type="checkbox"/> hearing aid <input type="checkbox"/> plastic surgery <input type="checkbox"/> other _____
<p>PSYCHIATRIC</p> <input type="checkbox"/> none <input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> dementia <input type="checkbox"/> other _____	<p>ENDOCRINE</p> <input type="checkbox"/> none <input type="checkbox"/> diabetes <input type="checkbox"/> thyroid <input type="checkbox"/> oral steroid use <input type="checkbox"/> other _____	<p>INFECTIONS</p> <input type="checkbox"/> none <input type="checkbox"/> hepatitis(circle): A or B or C <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> tuberculosis/TB <input type="checkbox"/> other _____	<p>GENTOURINARY</p> <input type="checkbox"/> none <input type="checkbox"/> dialysis <input type="checkbox"/> kidney problems <input type="checkbox"/> venereal disease/STD <input type="checkbox"/> other _____
<p>ALLERGIC/IMMUNOLOGIC</p> <input type="checkbox"/> none <input type="checkbox"/> seasonal/allergic <input type="checkbox"/> lupus <input type="checkbox"/> organ transplantation <input type="checkbox"/> cancer chemotherapy <input type="checkbox"/> other _____	<p>CONSTITUTIONAL</p> <input type="checkbox"/> none <input type="checkbox"/> Current Weight _____ <input type="checkbox"/> fever <input type="checkbox"/> chills <input type="checkbox"/> weight loss	<p>* Does your dentist ask you to take antibiotics before dental work? Y/N</p> <p>* Are you currently pregnant, planning to become pregnant, or nursing? Y/N</p> <p>* Are you allergic to latex or rubber? Y/N</p> <p>* Have you ever had radiation or UV treatments? Y/N</p> <p>* Previous anesthesia complications? Y/N</p>	

Allergies: Please list ALL medication allergies and describe reactions (If none, circle NONE): _____

Surgeries: (skin cancer, skin biopsies, and all other surgeries)(If none, circle NONE): _____

Hospitalizations/Other Illnesses: (If none, circle NONE): _____

Medications: Please list ALL PRESCRIBED MEDICATIONS AND DOSAGES as well as over the counter medications (include birth control pills, aspirin, pain relievers, vitamins, insulin, laxatives, herbal medications, etc.)(If none, circle NONE): _____

Family History (blood relatives only-list relationship to you):
PLEASE CHECK AND GIVE DETAILS

- No family history of skin cancer or other skin problems
 Increased number of moles/dysplastic moles _____
 Basal cell/squamous cell carcinoma _____
 Melanoma _____
 Other skin problems _____
 Other medical problems _____
 Anesthetic complications _____

Social Hx: Do you use sunscreen? _____
 How long have you been in AZ? _____
 Where did you grow up? _____

Tobacco Use: never used tobacco
 Age started _____ per day _____
 Age quit _____ or currently using _____

Alcohol: amount _____ per day/week

Occupation/Former Occupation: _____

Did you ever work outside (details)?: _____

Provider's Signature: _____ Assistant Signature: _____ Date: _____