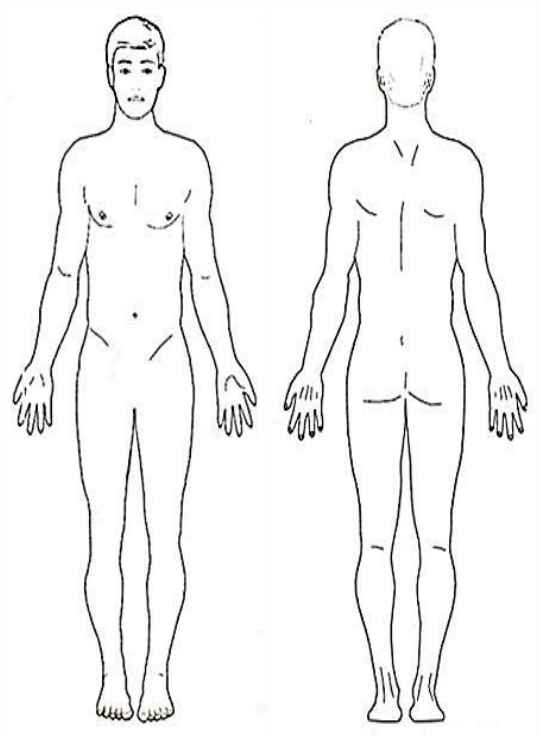
PiMA DERMATOLOGY
ADULT / PEDIATRIC / COSMETIC / LASER & SKIN SURGERY
5150 E. Glenn Street | Tucson, AZ 85712 | 520.795.7729 | f 520.795.4177 | www.pimaderm.com

MEDICAL HISTORY FORM

Today's Date: _____ /_____ /_____

PATIENT NAME: _____ **M / F** **Date of Birth:** _____ /_____ /_____
LAST NAME FIRST NAME

REASON FOR VISIT: (Mark on the diagram the location of your skin condition)
_____
_____
How long? _____ Past treatments, if any? _____
_____
_____



LIST ALL CURRENT MEDICATIONS:
(Include prescriptions and over-the-counter):
1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

PHARMACY INFORMATION:
Preferred Pharmacy Name: _____
_____
ADDRESS PHONE

ALLERGIES:
Are you ALLERGIC to any medications? **YES** **NO**
If yes, list below which medication(s) and what reaction(s):
_____
_____
Have you ever had a reaction to local anesthesia? **YES** **NO**
If yes, explain:
_____
Are you allergic to latex? **YES** **NO**
Do you develop skin rashes in reaction to the following?: (circle below)
Bandages Neosporin Polysporin Other _____

CURRENT SKIN CARE PRODUCTS:
_____
_____
_____

Do you wear sunscreen on a regular basis? YES NO

Do you wish to discuss your skin care today? YES NO

SKIN: Have you ever had the following?

- ❑ **Actinic Keratosis** (pre-cancerous lesions)
- ❑ **Basal Cell Carcinoma**
- ❑ **Squamous Cell Carcinoma**
- ❑ **Melanoma**
- ❑ Other _____

If yes, please provide details _____

Do you have a history of any skin diseases? **YES** **NO** If yes, please explain: _____

Have you had atypical/dysplastic moles? **YES** **NO** If yes, any removed? **YES** **NO** If yes, location?_____
Do you develop keloid scars in response to surgery? **YES** **NO**
Do you have any history of external skin radiation? **YES** **NO** If yes, explain: _____
_____

PATIENT NAME: _____

LAST NAME FIRST NAME

MEDICAL/SURGICAL HISTORY - Please check if any of the following conditions apply to you:

CARDIOVASCULAR:

- ❑ None
- ❑ Hypertension (high blood pressure)
- ❑ Myocardial Infarction (heart attack)
  If so, when _____
- ❑ Heart valve problems
  If so, type: _____
- ❑ Pacemaker / Defibrillator
- ❑ Other: _____

GASTROINTESTINAL:

- ❑ None
- ❑ Gastroesophageal Reflux Disease (GERD)
- ❑ Stomach Ulcer
- ❑ Colitis (ulcerative/chronic)
- ❑ Liver Disease
- ❑ Other: _____

GENITOURINARY:

- ❑ None
- ❑ Kidney Disease
- ❑ Dialysis

Other: _____

HEMATOLOGIC:

- ❑ None
- ❑ Anemia
- ❑ Bleeding Disorders
  If so, type:_____
- ❑ Other: _____

IMMUNOLOGIC:

- ❑ None
- ❑ Seasonal allergies
- ❑ Lupus

INFECTIOUS DISEASE:

- ❑ None
- ❑ Hepatitis If so, type: **A , B or C**
- ❑ HIV / AIDS
- ❑ Herpes
- ❑ STDs / VD
- ❑ Tuberculosis (TB)

Other: _____

METABOLIC / ENDOCRINE:

- ❑ None
- ❑ Diabetes

If so, type: _____

- ❑ Thyroid Disorder

MUSCULOSKELETAL:

- ❑ None
- ❑ Muscular Dystrophy
- ❑ Osteoarthritis
- ❑ Fibromyalgia
- ❑ Artificial Joint

If so, type: _____

NEOPLASTIC

- ❑ None
- ❑ Cancer (other than skin)

If so, type: _____

- ❑ Lymphoma

If so, type? _____

- ❑ Chemotherapy / Radiation /Surgery

If so, when: _____

NEUROLOGIC:

- ❑ None
- ❑ Dementia
- ❑ Multiple Sclerosis
- ❑ Seizure Disorder
- ❑ Peripheral Neuropathy
- ❑ Cerebrovascular Accident (stroke)

PSYCHIATRIC:

- ❑ None
- ❑ Depression
- ❑ Anxiety

PULMONARY:

- ❑ None
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ COPD

WOMEN'S HEALTH:

- ❑ Irregular Menstrual Cycle
- ❑ Polycystic Ovary Syndrome
- ❑ Hysterectomy

Are you pregnant? **Y N**
Are you nursing? **Y N**
Are you trying to get pregnant? **Y N**

OTHER:

Please list any other diseases or conditions we should be aware of:

_____
_____

Do you require antibiotics before dental procedures? **YES NO**

OTHER SURGERIES If yes, please explain type of surgery: _____

_____

FAMILY HISTORY:

Family history of Skin Cancer? **YES NO** If yes, type:_____

SOCIAL HISTORY:

Alcohol: amount _____ per day/week

Tobacco Use (circle): **Current**, Type: _____ **Former**, how long ago did you quit? _____ **Never**

Occupation/Former Occupation: _____

_____ _____
Patient Signature Parent / Guardian Signature

_____ _____
Provider Signature / MA Initial Date 02/2015