Paducah Dermatology, PLLC
Patient History Form

Date: _____Referring Provider: _____

Name:_____ Birth Date:_____ Age:_____ (circle one) Male Female

Females: Pregnant Yes ☐ No ☐ (Weeks_____) Trying to become pregnant? Yes ☐ No ☐

Drug Allergies:

List Name of Drug(s) below:	What type of allergic reaction?

Current Medications (both Rx and Herbal): Name of Medication & Dosage

Preferred Pharmacy and Location:

History of Present Illness

Problem 1:_____

- Location:_____
- Duration: _____
- Treatment ☐ None: _____
  - ☐ OTC: _____
  - ☐ Prescription: _____

- Symptoms & Severity
  - ☐ None
  - ☐ Itching-mild/mod/severe
  - ☐ Pain-mild/mod/severe
  - ☐ Bleeding-mild/mod/severe
  - ☐ Other_____

- Growths/Moles:(not for Rashes)
  - ☐ Changing Colors
  - ☐ Enlarging
  - ☐ Changing Shape
  - ☐ No Change

Comments: _____
_____

Problem 2:_____

- Location:_____
- Duration: _____
- Treatment ☐ None: _____
  - ☐ OTC: _____
  - ☐ Prescription: _____

- Symptoms & Severity
  - ☐ None
  - ☐ Itching-mild/mod/severe
  - ☐ Pain-mild/mod/severe
  - ☐ Bleeding-mild/mod/severe
  - ☐ Other_____

- Growths/Moles:(not for Rashes)
  - ☐ Changing Colors
  - ☐ Enlarging
  - ☐ Changing Shape
  - ☐ No Change

Comments: _____
_____

Problem 3:_____

- Location:_____
- Duration: _____
- Treatment ☐ None: _____
  - ☐ OTC: _____
  - ☐ Prescription: _____

- Symptoms & Severity
  - ☐ None
  - ☐ Itching-mild/mod/severe
  - ☐ Pain-mild/mod/severe
  - ☐ Bleeding-mild/mod/severe
  - ☐ Other_____

- Growths/Moles:(not for Rashes)
  - ☐ Changing Colors
  - ☐ Enlarging
  - ☐ Changing Shape
  - ☐ No Change

Comments: _____
_____

Family History (parents, siblings, grandparents) (Check appropriate box)

☐ Asthma ☐ (COPD) Lung Disease ☐ Eczema ☐ Hay Fever(Seasonal allergies) ☐ Psoriasis
☐ Stroke ☐ Cancer: Type:_____
☐ Skin Cancer: ☐ Basal Cell CA ☐ Squamous Cell CA ☐ Melanoma
☐ None ☐ Other_____

Social History (Check appropriate box)

Occupation (Job):_____☐ Tobacco Use - How many packs per day? _____
☐ Alcohol Use – How much per day? _____
☐ Sun Exposure: ☐ Work Outdoors ☐ Outdoor Recreation ☐ Tanning Beds

Skin Cancer and Sun Exposure History

☐ Sun Exposure: ☐ Work Outdoors ☐ Outdoor Recreation ☐ Tanning Beds
☐ Basal Cell Carcinoma _____Site _____Date _____ ☐ Multiple BCC_____
☐ Squamous Cell Carcinoma _____Site _____Date _____ ☐ Multiple SCC_____
☐ Melanoma: _____

Medical History: (Check appropriate box)

☐ Anemia	☐ Headaches	☐ Lung Disease
☐ Arthritis	☐ Hepatitis	☐ Lupus
☐ Asthma	☐ Herpes (Fever Blisters)	☐ Neurological Disease
☐ Bleeding Problems	☐ Hives	☐ Organ Transplant
☐ Coronary Artery Disease (Heart Disease)	☐ HIV Positive	☐ Psoriasis
☐ Diabetes	☐ Hypertension (High Blood Pressure)	☐ Seizure
☐ Eczema	☐ Keloids (Thick Scars)	☐ Thyroid
☐ Hay Fever (Allergies)	☐ Kidney Disease	☐ Cancers-Other than Skin: Type:_____ Date:_____

Surgical History: (Check appropriate box)

☐ Appendectomy (Appendix) ☐ Coronary Bypass Surgery ☐ Gallbladder
☐ Hip Replacement – Right or Left ☐ Knee Replacement – Right or Left ☐ Mastectomy (breast removed)
☐ PE Tubes (tubes in ears) ☐ Tonsillectomy (tonsils)
☐ Other _____

Immunizations: (Shots) and Last Date Received:

☐ Flu _____ ☐ Pneumonia _____ ☐ Tetanus_____
☐ Required Childhood Shots (If applicable) _____

_____ _____
Signature **Date**