PREMIER DERM SURGERY

Established Patient Medical History Form

Patient:_____ Date of Birth:_____ Date of Visit:_____

Address:_____ Ins Co:_____ ID#_____

Reason for today's visit: ☐ Routine skin check ☐ New Concern: _____

Body site(s) involved: _____

When did it begin? _____

What symptoms are associated? ☐ None ☐ Bleeding ☐ Scabbing ☐ Crusting ☐ Never seems to heal ☐ Tenderness ☐ Irritation ☐ Other: _____

Was this ever treated before? ☐ No ☐ Yes: ☐ Surgery ☐ Freezing/Burning ☐ Medication: _____

Please list your current medications: _____

_____

Do you take aspirin, Plavix, or Coumadin/warfarin? Yes ☐ No☐

Do you have any allergies to medications? Yes ☐ No☐ Pharmacy Name / Phone: _____

If yes, list medication and reaction type:_____

_____

Please check appropriate NEW medical conditions since your last visit:

☐ **Please check here if there has been no change in medical history since last visit**

General
- ☐ Unexplained fever
- ☐ Unexplained weight change
- ☐ Night sweats
- ☐ Anorexia
- ☐ Other:

Skin
- ☐ Abnormal scarring
- ☐ Poor wound healing
- ☐ Sensitive skin
- ☐ Cold sores/fever blisters
- ☐ Other:

Infectious Disease
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Other:

Cardiac
- ☐ **PACEMAKER**
- ☐ **DEFIBRILLATOR**
- ☐ Bypass surgery
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Chest pain
- ☐ Other:

Pulmonary
- ☐ Shortness of breath
- ☐ Cough
- ☐ Asthma
- ☐ Other:

Endocrine
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Other:

Gastrointestinal
- ☐ Nausea/vomiting/diarrhea
- ☐ Colon polyp or cancer
- ☐ Irritable bowel disease
- ☐ Other:

Renal/Urology
- ☐ Dialysis
- ☐ Prostate disease
- ☐ Other:

Orthopedic
- ☐ Artificial joint
- ☐ Prosthesis
- ☐ Other:

Hematologic:
- ☐ Bleeding disorder
- ☐ Easy bruising
- ☐ Blood clots
- ☐ Other:

Immune system
- ☐ Organ transplant Type:_____
- ☐ Previous or current cancer Type:_____
- ☐ Current or past chemotherapy
- ☐ Other:

Neurologic
- ☐ Stroke
- ☐ Dizziness
- ☐ Weakness or arms/legs
- ☐ Decreased sensation
- ☐ Other:

Ob/gyn
- ☐ Currently pregnant
- ☐ Trying to conceive
- ☐ Hysterectomy
- ☐ Frequent yeast infections
- ☐ Other:

Please list any other **NEW** medical conditions since last visit: _____

Please list any surgeries **since last visit**: _____

Skin Cancer and Surgery Related Questions:

Have you ever had a sunburn? Yes ☐ No☐ Do you have a family history of skin cancer? Yes ☐ No☐ Uncertain☐

Have you previously used a tanning booth? Yes ☐ No☐ Do you currently or periodically use a tanning booth? Yes ☐ No☐

Do you take sun protective measures? ☐ No ☐ Yes: Sunscreen ☐ Sunglasses ☐ Hat ☐ Avoiding midday sun ☐

How often do you monitor your skin for sun damage/cancer? ☐ Not regularly ☐ Monthly self check ☐ Routine check-up w/ Dr.

Occupation: _____ Hobbies: _____

Smoking status: Never ☐ Former ☐ Current ☐ If current smoker, how many packs per day? _____

Do you drink alcohol? Yes ☐ No☐ If yes, how many drinks per week? _____

This form was completed by: ☐ Patient ☐ Family or friend ☐ Medical Staff_____ Initials

Patient accompanied by: ☐ Spouse ☐ Other family member: ☐ Parent ☐ Friend

I hereby acknowledge that the completed information is accurate.

Signature of Patient:_____ Date:_____

Reviewed by:_____ Date:_____

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