PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY FORM

Name _____ Date_____

Referred by: ❑ M.D.: _____ ❑ Self/Friend

Date of Birth: _____ Age_____ Sex: ❑ M ❑ F

Main skin problem you want evaluated? _____

1. **Body area:** _____ **Duration:** _____
2. **Previous treatments (all medicines used):** ❑ None
   _____
3. **Changes:** ❑none ❑ color ❑ size ❑ elevation ❑ hardness
4. **Modifying factors:** ❑ none ❑ history of sun exposure ❑ other immune diseases ❑ other illness
5. **Symptoms:** ❑none ❑ bleed ❑ itch ❑ pain ❑ infection
6. **Severity:** ❑ none ❑ occasional ❑ constant

Complete list of all other skin areas, growths, skin symptoms, or questions you have:

1. _____
2. _____
3. _____
4. _____

MEDICAL HISTORY ❑None Illness, surgeries, hospitalizations and dates: ❑ Continued on other side
List: _____

Current or past health problems:
❑ **None**
❑ Glaucoma ❑ Asthma ❑ Hay Fever/Sinus ❑ Hypertension
❑ Anemia ❑ Herpes ❑ Pacemaker ❑ Prostate Prob.
❑ Cancer ❑ Tuberculosis ❑ Kidney Stones ❑ Coronary Heart Disease
❑ Seizures ❑ Hepatitis ❑ Heart Murmur ❑ Artificial Heart Valve
❑ Arthritis ❑ Stroke ❑ Thyroid Disease ❑ Irreg. pulse/heartbeat
❑ Colitis ❑ Depression ❑ Peptic ulcer disease ❑ Migraine Headaches
❑ HIV/AIDS ❑ Diabetes ❑ Venereal Disease
❑ Other medical (explain) _____

Current or past skin problems:
❑ **None**
❑ Eczema ❑ Rash
❑ Abnormal moles ❑ Hives
❑ Frequent sun exposures ❑ Melanoma
❑ Excessive scarring ❑ Psoriasis
❑ Recent or progressive hair loss
❑ Precancer spots (actinic Keratosis)
❑ Other skin cancer: _____

CURRENT MEDICATIONS All prescriptions, over-the-counter, vitamin and supplements (including herbal)
❑None
List: _____

PREGNANCY ❑ Yes ❑ No ❑ Current Contraceptive Methods:_____ ❑ N/A

ALLERGIES ❑ None
List: _____

FAMILY HISTORY
❑ None
❑ Melanoma ❑ Eczema ❑ Diabetes ❑ Hay Fever ❑ Cancer ❑ Psoriasis ❑ Asthma ❑ Other Skin Cancer
❑ Other _____

SOCIAL HISTORY Occupation_____
Martial Status: ❑ S ❑ M ❑ D ❑ W
Smoking: ❑ No ❑ Former ❑ Yes: how many packs/day? _____
Alcohol: ❑ No ❑ Social/occasional drinking only
Alcohol or drug problems/addictions: ❑ No ❑ Yes ❑ Describe: _____

CURRENT SYMPTONS (check all that apply) ❑ None
❑ Fevers/chills/weight loss ❑ Headaches/visual hearing problems ❑ Heart/breathing problems ❑ Bone/joint pain
❑ Stomach/intestinal problems ❑ Urinary or kidney problems ❑ Sweats or hair loss ❑ Easy bruising
❑ Neurological/psychological problems ❑ Enlarged glands or bleeding problems
❑ Other skin symptoms, list: _____

_____ Patient Signature

_____ Provider Signature

© Bernard Raskin 1999, 2007