Advanced Dermatology & Cosmetic Surgery

Medical History Form

Name: _____ Date: _____

Preferred Pharmacy

Name: _____ Primary Care Physician_____

Phone Number: _____ Referring Physician_____

City or Zip Code: _____

Do we have permission to import medication from your pharmacy ☐ Yes ☐ No

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis/Joint problems
- ☐ Asthma
- ☐ (AF) Irregular Heartbeat
- ☐ Bone Marrow Transplant
- ☐ BPH (Enlarged prostate)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis A/B/C
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ High cholesterol
- ☐ Overactive Thyroid (Hyper)
- ☐ Low Thyroid (Hypo)
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other

_____

_____

_____

☐ NONE

Past Surgical History

Have you had any surgeries on the following organs (Please circle appropriate location or condition)

- ☐ Appendix
- ☐ Bladder
- ☐ Breast Biopsy
- ☐ Breast: Lumpectomy (Both, Left or Right)
- ☐ Breast: Mastectomy (Both, Left or Right)
- ☐ Colon: Cancer Resection
- ☐ Colon: Diverticulitis
- ☐ Colon: Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder
- ☐ Heart Valve Replacement (Tissue or Mechanical)
- ☐ Heart Bypass
- ☐ Heart Transplant
- ☐ PTCA (Angioplasty or Stent)
- ☐ Joint Replacement – Knee: Right, Left or Both Sides
- ☐ Joint Replacement – Hip: Right, Left or Both Sides

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- ☐ Kidney: Biopsy, Stone Removal, Transplant, Removal
- ☐ Liver: Partial removal, transplant or shunt
- ☐ Ovaries removal: Endometriosis, Cancer or Cysts
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Partial removal
- ☐ Prostate: Biopsy, Cancer or TURP
- ☐ Rectum: APR- Resection of the Rectum
- ☐ Skin: Basal Cell, Squamous Cell, Melanoma
- ☐ Spleen (Removal)
- ☐ Testicles (Removal)
- ☐ Uterus: (Removal) Fibroids, Uterine or Cervical Cancer
- ☐ Other

_____
_____
_____

Females Only:

Are you currently pregnant? ☐ Yes ☐ No
LMP: _____

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma Skin Cancer
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Other _____
- ☐ NONE

Do you wear Sunscreen?

☐ Yes ☐ No

If yes, what SPF? _____

Do you tan in a tanning salon?

☐ Yes ☐ No

Family History

Do you have a family history of Melanoma? ☐ **Yes** ☐ **No**

If yes, which family member(s)?

_____
_____
_____
_____

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Medications

List all current medications: (Please include dosage and strength if known)

_____
_____
_____
_____
_____

Allergies

List all allergies and reactions if known:

_____
_____
_____

Social History

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day