All Dermatology

ARROWHEAD BILTMORE / ARCADIA SURPRISE

Patient Medical History Form

Patient Name ______________________________________ Date of Birth ____________
Last First Middle Initial

Patient's Primary Doctor______________________________ Office Phone # ( ) ____________

Doctor's Office Address__________________________ City State Zip ____________________

Pharmacy ______________________________________ Phone # ( ) ____________

Pharmacy Address __________________________ City State Zip ____________________

Are you currently pregnant? NO / YES **Are you currently breast feeding?** NO / YES

Do you have a history of: Blistering sunburn No / Yes - Tanning bed use No / Yes - Radiation or X-ray treatments No / Yes

Do you smoke? No / Yes If yes, how many packs a day ________ How long have you smoked? ________ years.

How much alcohol do you consume?____

Have you ever had a skin cancer? NO / YES

If yes, what kind (*circle all that apply*): **Basal Cell Carcinoma / Squamous Cell Carcinoma / Melanoma**

Where on your body and when?:____

Is there a family history of skin cancer? NO / YES If yes, who in your family and what kind of cancer?:

____

Drug allergies: Have you ever had an allergic reaction to any drug or medication? YES / NO

If yes, please list the drug(s) and type of reaction(s):

____

____

Have you ever had a latex allergy? NO / YES **Have you ever had a tape allergy?** NO / YES

Medications: Please list all prescription and non-prescription medications. Include any over-the-counter drugs, herbs, vitamins, or supplements you are taking or have taken within the past month.

____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

Medical History: Do you now, or have you ever had, any of the following conditions (*circle all that apply*):

Allergies / Hay Fever	Cancer (not skin) Please list below	Faint Easily	Infections (frequent)	Post Nasal Drip
Anxiety Problems	Chest Pain	Headaches	Itchy / Burning Eyes	Psoriasis
Arthritis	Chronic Cough	Heart Attack / Heart Failure	Keloids	Runny Nose
Asthma	Depression	Hepatitis	Liver Disease	Shingles
Autoimmune Disease	Diabetes	High Blood Pressure	Lupus	Sinusitis
Bleeding Tendency	Eczema	HIV / AIDS	Migraines	Stroke
Bronchitis (chronic)	Emphysema / COPD	Hives	Pacemaker	Thyroid Disease

Please list any Cancer (not skin) that you have had ______________________________

____

Please list any other medical issues you have had, if not listed above______________________

____

Do we have your permission to:

Leave a message on your answering machine at home about your medical condition? NO / YES

Leave a message at your place of employment? NO / YES If yes, phone # ________________

Discuss your medical condition with any members of your household? NO / YES

Contact you by email? NO / YES If yes, list email address______________________

If yes, whom: ______________________________ Relationship: ____________

Patient Signature: ______________________ **Date:**__________ *Physician Initials:*__________

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