



Medical History

First Name: _____ MI: _____ Last Name: _____ DOB: ____/____/____ Date: _____

Health History

Main Reason for Today's Visit: _____

Are you pregnant or trying to get pregnant? Yes No

Past Medical History

Select any of the following medical conditions you currently have:

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- Bone Marrow Transplant
- Benign Prostate Hypertrophy
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression

- Diabetes
- End Stage Renal Disease
- GERD
- Hearing Loss
- Hepatitis
- Hypertension
- HIV / AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Leukemia

- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- NONE
- Other

Past Surgical History

Have you had any surgeries on the following organs?

- Appendix (Appendectomy)
- Bladder (Cystectomy)
- Breast: Breast Biopsy, Lumpectomy, Mastectomy
- Colon (Colectomy): Colon Cancer, Diverticulitis, IBD
- Gallbladder removed
- Heart: Bypass, Valve Replacement, Angioplasty
- Heart: Transplant
- Joint Replacement (Circle):

Hip, Knee, Shoulder

- Kidney: Biopsy, Stones
- Kidney: Transplant
- Kidney: Nephrectomy
- Liver: Hepatectomy, Shunt
- Liver: Transplant
- Ovaries: Ovarian Cancer
- Ovaries: Tubal Ligation
- Pancreas: Pancreatectomy
- Prostate: Biopsy, TURP
- Prostate: Prostate Removal

- Colon/Rectal resection
- Spleen: Splenectomy
- Testicles: Orchiectomy
- Uterus (Hysterectomy): Fibroids
- Uterus (Hysterectomy): Uterine Cancer, Cervical Cancer
- NONE
- Other



Medical History

Skin Disease History

Have you had any of the following?

- Actinic Keratoses
- Basal Cell Skin Cancer
- Blistering Sunburns
- Melanoma: Year _____ Body Location _____
- Atypical/Dysplastic Moles
- Squamous Cell Skin Cancer
- Psoriasis
- None
- Other _____

Do you wear Sunscreen?

- Yes No

If yes, what SPF? _____

Do you tan in a tanning salon or have you used one in the past?

- Yes No

Medications

List all current medications with doses: (if you have a list, write See List and we will make a copy)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Allergies

List all medication allergies and reactions if known:

Name:

Reaction:

_____	_____
_____	_____
_____	_____
_____	_____



Medical History

Social History

Smoking Status (please choose one):

- Current everyday smoker
- Current someday smoker
- Former smoker
- Never smoker
- Unknown if ever smoked

If Current Smoker, then Number of Packs Per Day: _____

Alcohol Intake (please choose one):

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

Family History

Do you have a Family History of:

Melanoma: Yes No If Yes, then relationship to the person: _____

Other Medical Information

Do you have a living will? Yes No
 Do you have a Medical Power of Attorney (for yourself)? Yes No

If Yes, please list the person _____

Review of Systems

Please check yes or no for the following:

Symptom	Yes	No
Are you generally in good health?		
Do you have problems with bleeding?		
Do you have problems with healing?		
Do you have problems with scarring?		
Do you currently have a rash?		
Do you have any new skin lesions?		
Do you have any changing skin lesions?		
Are you immunocompromised?		



Medical History

Alerts

Please check yes or no for the following:

Symptom	Yes	No
Allergy to adhesive?		
Allergy to latex?		
Allergy to lidocaine?		
Artificial valve replacement?		
Artificial joint replacement?		
Blood thinners?		
Defibrillator?		
Keloid scarring?		
MRSA?		
Pacemaker?		
Require antibiotics prior to procedures?		
Rapid heartbeat with epinephrine?		
Other:		

Consent to Photograph:

Your Doctor or his staff may choose to take medical photographs to be part of your medical record for purposes of documentation of procedures and for comparison before and after treatment.

I understand I will not receive payment from any party for these photographs

I understand that these photographs are for medical purposes only and my identity will not be disclosed other than for purposes in my medical record

_____ Initials

Laboratory Fees:

I understand that all outside laboratory and pathology testing will be billed from the specific laboratory to me and/or my insurance company. I accept payment responsibilities if my insurance denies payment.

_____ Initials

Pharmacy Medication Management Information:

In order to ensure we have the most accurate and up-to-date information on your medications, we are able to import all of your current medications directly from your pharmacy(s) into our Electronic Health Records via a SECURE connection. I agree that Bluewater Dermatology and Skin Cancer Center, PA can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

_____ Initials

Patient Signature: _____ Print Name: _____ Date: ____ / ____ / ____
 (or Legal Representative)