Medical History

First Name: ____________________ MI: ____ Last Name: __________________________________ 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
- ☐ BPH
- ☐ 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: Hip, Knee
- ☐ 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 Cancer
- ☐ Rectal resection
- ☐ Spleen: Splenectomy
- ☐ Testicles: Orchiectomy
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer, Cervical Cancer
- ☐ NONE

Medical History

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Have Fever / Allergies
- ☐ Melanoma: Year ____ Body Location __________
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ NONE
- ☐ Other

____

____

Do you wear Sunscreen?

○ Yes ○ No

If yes, what SPF? __________

Do you tan in a tanning salon?

○ Yes ○ No

Medications

List all current medications: (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

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

Please include your relation to the relative:

Family History of Melanoma: _______________________________
Family History of Psoriasis: _________________________________
Family History of Eczema: __________________________________

Other Medical History

Have you had a flu vaccine this year? Yes No
Have you previously had a pneumonia vaccine? Yes No
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 name ____________________

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)