

MEDICAL HISTORY Please circle correct responses or fill in the blanks where applicable.

Today's Date _____

Name _____ Birth Date _____ Height _____ Weight _____

1. Do you have, or have you ever had the following?

High Blood Pressure	yes	no	Gout	yes	no
Diabetes	yes	no	Seizures or Epilepsy	yes	no
Heart Disease or Heart Attack	yes	no	Ulcers	yes	no
Thyroid Disease	yes	no	Tuberculosis	yes	no
Stroke	yes	no	Glaucoma	yes	no
Jaundice or Hepatitis	yes	no	Allergies (Hay Fever)	yes	no
Cancer (if yes, please specify)	yes	no	Asthma	yes	no

2. List all operations, hospitalizations, or serious illnesses: _____

Pacemaker? _____ Artificial Joints? _____

3. List any skin surgery that you have had and its location(i.e. mole removed, cyst removed, etc.):

4. List any skin problems you have consulted a dermatologist for: _____

5. Have you ever had skin cancer?_____ If yes, please specify the type (if known) and location.

6. Have you ever had x-ray treatments or radiation treatments? Yes No

7. List any family history of skin problems including skin cancer, acne, psoriasis, eczema, etc.:

Father _____

Mother _____

Sibling _____

Other _____

8. List any medications that you are currently taking including over-the-counter medicines and herbal supplements. _____

9. List any medication allergies. _____

10. Social History: Tobacco_____ Alcohol_____

11. When exposed to the sun without protection, do you: Burn Burn-Tan Tan Only

OFFICE USE ONLY _____
