Palm Beach Dermatology
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Medical History Form

Patient Name:_____ Age: _____

Reason for visit:_____

Medical History: Have you ever had the following diseases or conditions: (Please check YES or NO)

	Y	N		Y	N		Y	N
Anxiety	_	_	Depression	_	_	Hypothyroidism	_	_
Arthritis	_	_	Diabetes	_	_	Leukemia	_	_
Asthma	_	_	End stage renal disease	_	_	Lung cancer	_	_
Atrial fibrillation	_	_	GERD	_	_	Lymphoma	_	_
Bone marrow transplantation	_	_	Hearing loss	_	_	Prostate cancer	_	_
Benign prostatic hyperplasia	_	_	Hepatitis	_	_	Radiation treatment	_	_
Breast cancer	_	_	Hypertension	_	_	Seizures	_	_
Colon cancer	_	_	HIV/AIDS	_	_	Stroke	_	_
COPD	_	_	High cholesterol	_	_	Other _____		
Coronary artery disease	_	_	Hyperthyroidism	_	_			

Surgical History: Have you ever had any surgeries on the following organs: (Please check YES or NO)

	Y	N		Y	N		Y	N
Appendix Removed	_	_	Heart: Mechanical valve	_	_	Ovaries removed: cyst	_	_
Bladder removed	_	_	Heart: Angioplasty	_	_	Ovaries: tubal ligation	_	_
Breast biopsy	_	_	Hip replacement (both)	_	_	Pancreas removed	_	_
Lumpectomy (both breasts)	_	_	Hip replacement (left)	_	_	Prostate biopsy	_	_
Lumpectomy (left breast)	_	_	Hip replacement (right)	_	_	Prostate cancer	_	_
Lumpectomy (right breast)	_	_	Knee replacement (both)	_	_	Prostate removal for BPH	_	_
Mastectomy (both breasts)	_	_	Knee Replacement (left)	_	_	Rectum resection APR	_	_
Mastectomy (left breast)	_	_	Knee Replacement (right)	_	_	Rectum resection low anterior	_	_
Mastectomy (right breast)	_	_	Kidney biopsy	_	_	Skin: basal cell carcinoma	_	_
Colectomy: colon cancer resection	_	_	Kidney stone removal	_	_	Skin: melanoma	_	_
Colectomy: diverticulitis	_	_	Kidney transplant	_	_	Skin: biopsy	_	_
Colectomy: inflammatory bowel	_	_	Kidney removal	_	_	Skin: squamous cell carcinoma	_	_
Colon: colostomy	_	_	Liver removal	_	_	Spleen removed	_	_
Gallbladder removal	_	_	Liver transplant	_	_	Testicle removed	_	_
Heart: biologic valve replacement	_	_	Liver shunt	_	_	Hysterectomy: fibroids	_	_
Heart: bypass surgery	_	_	Ovaries removed: endometriosis	_	_	Hysterectomy: uterine cancer	_	_
Heart: Transplant	_	_	Ovaries removed: cancer	_	_	Hysterectomy: cervical cancer	_	_

Other _____

Skin Disease: Have you ever had any of the following conditions: (Please check YES or NO)

	Y	N		Y	N		Y	N
Acne	_	_	Dry skin	_	_	Poison ivy	_	_
Actinic keratosis	_	_	Eczema	_	_	Precancerous moles	_	_
Asthma	_	_	Flaking or itching scalp	_	_	Psoriasis	_	_
Basal cell skin cancer	_	_	Hayfever/allergies	_	_	Squamous cell skin cancer	_	_
Blistering sunburns	_	_	Melanoma	_	_	Other _____		

Skin History:

Do you wear sunscreen? (Circle) Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? (Circle) Yes No
Do you have a family history of melanoma? (Circle) Yes No
If yes, which relative(s)? _____

Medications: (Please list all current medications)

_____
_____
_____

Allergies: (Please list all allergies)

_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:	Alcohol Use:	Sexual Activity:
Never smoked	None	Not sexually active
Quit: former smoker	Less than 1 drink per day	Sexually active with 1 partner
Smoker (packs/ day ___, total yrs___)	1-2 drinks per day	Sexually active with more than 1 partner
	3 or more drinks per day	Same sex partner

Race: (Circle all that apply)	Ethnicity: (Circle)	Preferred language
White	Hispanic/Latino	English
Black/African American	Non-Hispanic/Latino	Spanish
Asian		Other
American Indian or Native American		

Other:

Do you drive during the day? Yes No
Do you drive at night? Yes No
How often do you exercise? _____
Describe your caffeine use: _____
If you are over 65, how many times in the past year have you had 5 or more alcoholic drinks for men or 4 or more drinks for women? _____
Occupation and Workplace: _____
Place of Residence: _____

Systems Review: Do you have any of the following issues: (Please check YES or NO)

	Y	N		Y	N		Y	N
Problems with bleeding	_	_	Unintentional weight loss	_	_	Neck stiffness	_	_
Problems with healing	_	_	Thyroid problems	_	_	Headaches	_	_
Problems with scarring	_	_	Sore throat	_	_	Seizures	_	_
Rash	_	_	Blurry vision	_	_	Cough	_	_
Immunosuppression	_	_	Abdominal pain	_	_	Shortness of breath	_	_
Hay fever	_	_	Bloody stool	_	_	Wheezing	_	_
Chest pain	_	_	Bloody urine	_	_	Anxiety	_	_
Fever or chills	_	_	Joint aches	_	_	Wheezing	_	_
Night sweats	_	_	Muscle weakness	_	_	Other _____		

Alerts: Do you have any of the following issues: (Please check YES or NO)

	Y	N		Y	N		Y	N
HIV Positive	_	_	Allergy: adhesive	_	_	MRSA	_	_
Hep C positive	_	_	Allergy: lidocaine	_	_	Pacemaker	_	_
Epi sensitivity	_	_	Allergy: topical antibiotic	_	_	Premed prior to procedure	_	_
Taking Plavix	_	_	Artificial heart valve	_	_	Rapid heartbeat with epi	_	_
Taking Coumadin	_	_	Artificial joint (past 2 yrs)	_	_	Pregnant or planning to become pregnant	_	_
Taking Aspirin	_	_	Blood thinners	_	_	West Africa travel	_	_
Taking Xarelto	_	_	Defibrillator	_	_	Risk of Ebola	_	_

Family History: Describe any family history (only first degree relatives)

_____

_____

_____

Pharmacy:

Name: _____
Street address: _____
Zip Code: _____
Phone Number: _____

Do you consent to allowing our office to import your pharmacy prescriptions medications ❑ Yes ❑ No

Completed by: ❑ Patient Signature:_____ _____/_____/_____
Date

❑ Parent Print Name: _____