

Name _____

Birthdate ____ / ____ / ____

Height _____ Weight _____

All Medications/Supplements
 (or attach list)

Medication Allergies

Your Medical History

Skin Cancer **Yes / No**
 Other Cancer **Yes / No**
 Type _____
 Hepatitis **Yes / No**
 Diabetes **Yes / No**
 High Blood pressure **Yes / No**
 Heart problems **Yes / No**
 Pacemaker **Yes / No**

Other Medical Problems:

 Surgeries:

Skin History

Radiation treatments **Yes / No** Reason _____
 History of blistering burns **Yes / No**
 Tanning bed use **Past / Present / Never**
 Sunscreen user **Yes / No**

Family History

Skin Cancer / Eczema
 Psoriasis / Acne
 None of the above
 Other

Who _____

Social History

Occupation _____

Who do you live with?

Smoker **Current / Former / Never**

Alcohol **Yes / No**

System Review - Please circle your current symptoms

Chest pain / Poor circulation / Leg Swelling

General Health: Good / Fair / Poor

Fever / Loss of appetite / Night Sweats /

Weakness / Weight Change

Changing lesions / Dry Skin / Itching / Rash

Sores in Nose / Sores in Mouth / Dry Mouth

Nasal Congestion / Difficulty Swallowing

Hearing Loss / Nose Bleeds / Abdominal Pain /

Constipation / Diarrhea / Back Pain

Muscle Weakness / Joint Pain / Muscle Pain

Dizziness / Headaches / Burning in Hands or Feet

Change in Vision / Dry or Itchy Eyes / Anxiety

Depression / Cough / Shortness of Breath / Wheezing

 Patient signature

 Date

 MD signature

 Date