Dermatology Patient Health History Form

Allergies:
- □ None
- □ Latex
- □ Band-Aid/Adhesive
- □ Medication Allergies (List Below)

General/Social Information:

Any nicotine in the last 12 months? □ Yes □ No
□ Cigarettes □ Cigars □ Pipe □ Ecig □ Gum/patch

Are you a former smoker? □ Yes □No

If yes, when did you quit? _____

Do you drink alcohol? □ Yes □ No

Do you use illicit drugs (cocaine, marijuana, methamphetamines)? □ Yes □ No

Are you pregnant or nursing? □ Yes □ No

Current Occupation/Employment (Please circle)

Retired Disabled Working as _____

Personal History of Skin Cancer? □ Yes □ No

If so, which type? _____

If so, where was it? _____

Family History of Skin Cancer? □ Yes □ No

If so, which type? _____

Tanning Bed Use? □ Yes □ No

Sunscreen Use? □ Yes □ No

Please List All Current Medications

Prescription and Over The Counter Drugs:

Do you take any blood thinners? □ Yes □ No

If so, which one(s)? _____

Please List Current Health/Medical Problems

Please List Previous Surgeries

Pacemaker?	□ Yes	□ No
Stents or Valves?	□ Yes	□ No
Joint Replacement?	□ Yes	□ No
Organ Transplant?	□ Yes	□ No

If so, when? _____

How did you hear about us? □ Internet/Google □ Friend □ Social Media □ Newspaper □ Doctor Referral

Referred by _____