

**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?         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stents or Valves?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Joint Replacement? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Organ Transplant?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If so, when? \_\_\_\_\_

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

**Referred by** \_\_\_\_\_