Perfect Skin Dermatology
Medical History Form

Name_____ **Date**_____

Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis (Type_____)
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
None
Other_____

Past Surgical History: (Please circle all that apply)

Appendix removed
Bladder removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder removed
Coronary Artery Bypass
PTCA
Mechanical Heart Valve Replacement
Biological Heart Valve Replacement
Heart Transplant
Joint Replacement Knee (Right, Left, Bilateral) Year_____
Joint Replacement Hip (Right, Left Bilateral) Year_____
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant (Year_____)
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Carcinoma Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removal
Testicles Removed (Right, Left)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
NONE
Other:_____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Carcinoma: Where?_____
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itching Scalp
Hay Fever/Allergies
Herpes Simple
Melanoma: Where?_____
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Carcinoma: Where?
_____
NONE
Other Skin Disease History:_____

Do you wear sunscreen? **Yes No** If yes, what SPF? _____

Do you or have you ever tanned in a tanning salon? **Yes No**

Do you have a family history of Melanoma? **Yes No**
If yes, which relative(s)? _____

Please list any cosmetic/elective procedures you have had performed: _____
_____

Current Medication List: (Please list all medications and dosages, both prescription and non-prescription.) ****we will be happy to make a copy of your medication list***
_____
_____
_____
_____

Allergies: _____

Please list the name and address of your current pharmacy: _____
_____

Tobacco Usage:
- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes Daily
- Other:_____

Alcohol Usage:
- None
- Less than 1 drink daily
- 2-3 drinks daily
- 3 or more drinks daily

Recreational Drug Use: Yes No If yes, please list: _____

Females: Are you pregnant or breastfeeding? Yes No

Are you currently experiencing any of the following?

Problems with bleeding/blood thinners	**Yes No**
Problems with healing	**Yes No**
Problems with keloid scarring	**Yes No**
Immunosuppression	**Yes No**
Fever/Chills	**Yes No**
Unintentional Weight Loss	**Yes No**
Joint Aches	**Yes No**
Anxiety	**Yes No**

Other notable symptoms:_____

Information listed below is required of us to ask to capture data for a core government objective. The data is used to determine demographic disposition for certain types of diseases. You have the right to decline answering these questions.

Race:
- ☐ Declined
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ Other Race

Ethnic Group:
- ☐ Declined
- ☐ Hispanic or Latino
- ☐ **Not** Hispanic or Latino
- ☐ Other_____

Language:
- ☐ English
- ☐ Spanish
- ☐ Other_____