2021 MEDICAL HISTORY FORM – DiPRETA DERMATOLOGY

Pt Name:_____ **Birthdate:** __/__/____ **Age:**____ ***Acct:***_____

What is your occupation? _____ **Hobbies?** _____
Preferred Pharmacy:_____ **Pharmacy Address**_____ **Do you use mail order? Y N**

Reason for Your Visit Today: _____
Symptoms _____ Any Treatment Tried: _____

Med Hx Please mark IF applicable for you:	**Yes**	**No**		**Yes**	**No**
Cardiovascular	□	□	Gastrointestinal....	□	□
Bleeding Problems	□	□	Arthritis.....	□	□
Diabetes? Type? ..... _____	□	□	Hepatitis (A,B or C).....	□	□
High Blood Pressure.....	□	□	HIV (AIDS)	□	□
Pacemaker	□	□	TB (Tuberculosis)...	□	□
Defibrillator?	□	□	STD?	□	□
Joint Replacement? _____	□	□	Stent? Where....	□	□

MEDICATIONS: **(prescription, over the counter, vitamins, and dosage)** ____□ **See Attached List**

_____

Do you take blood thinners including herbal types? N Y ***If yes,*** please circle which ones you take:
Aspirin, Coumadin, Plavix, Warfarin, Vit E, Fish Oil, Feverfew, Saw Palmetto, Glucosamine, Ginger, Ginseng, Garlic,Xarelto
Other (list)_____

ANY ALLERGIES? **(medications, latex, tape, seasonal, anesthesia)** _____

_____

List all surgeries? _____

Personal History of Any Cancer? N Y _____ ***Enter Estimated*** **Height:** **Weight (lbs):**____

SKIN CONDITIONS and HISTORY

Have you had skin cancer?	**NO** □	**YES**	**If Yes, Please list When? Where? By?**
Melanoma (Malignant Melanoma/MM)		□	_____
Basal Cell Carcinoma (BCC)		□	_____
Squamous Cell Carcinoma (SCC)		□	_____
Have you had abnormal/dysplastic moles? Nevus?	**NO** □	**YES** □	_____
Have you had pre-cancerous or actinic keratosis?	**NO** □	**YES** □	_____

List any other skin conditions you have (*examples: eczema, psoriasis, acne, rosacea, vitiligo, keloids/scars)*

_____

Family History: Anyone in your family had **malignant melanoma**? Y N Who? _____
Any Family history of skin cancer? Y N Who? _____

Social History:

	Mark Y or N	
Did you get a flu/influenza shot? ...	____	If yes, when/where? _____
Did you get a pneumonia shot?	____	If yes, when? _____
Do you drink alcohol?.....	____	If yes, how much? Use Socially Use Daily
Do you smoke?.....	____	If yes, how much: Never Sometimes When did you start?____
Do you use sunscreen?.....	____	

FOR WOMEN ONLY: Type of Birth Control (if applicable)_____ *Are you pregnant? Y N Are you breastfeeding? Y N*

Medical photographs: I am aware and consent for medical photographs to be made of me (or my child, or person for whom I am legal guardian)**. I understand the information in my medical record is used for my continuum of care.**

Patient Signature: _____ **Date:** _____
Parent/Guardian Signature *(if minor <18):* _____ Relationship to Pt: _____