MEDICAL HISTORY FORM

Today's date:	**Referring physician**:		
Last name: First:		Middle	Birth date: / / Sex: □ Male □ Female

Primary Language:□ English □ Spanish □ Arabic □ Other **Ethnicity:** □ Hispanic or Latino

Race:□ American Indian □ Asian □ African American or Black □ Native Hawaiian/Other Pacific □ White □ Unknown □ Other

REASON FOR TODAY'S VISIT

Concern:	Location:	Duration:	Prior Treatments:
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PAST MEDICAL HISTORY

Adhesive/Latex allergy □Yes No	Bleeding disorders□Yes No	HSV/cold sore□Yes No	HIV positive □Yes□No
Local anesthetics allergy □Yes □No	Immunosuppressed □Yes □No	Diabetes □Yes□No	Hepatitis □Yes □No
Epinephrine sensitivity□Yes□No	Heart disease □Yes □No	Kidney disease □Yes □No	MRSA □Yes □No
Topical allergy □Yes □No	Lupus □Yes□No	Asthma/Hay fever □Yes □No	

FOR WOMEN ONLY - ARE YOU PREGNANT?□YES □NO ARE YOU ON BIRTH CONTROL? □ YES □ NO

Are you breastfeeding? □ Yes □ No Do you have regular menstrual cycles? □ Yes □ No

SKIN CANCER HISTORY

Do you (or family member) have a history of melanoma?Self □Yes□No

Family member □Yes□No

Do you (or family member) have a history of other skin cancer(s)?Self □ Yes□ No

Family member □ Yes □ No

If yes, list type, site and year diagnosed:

WHAT IS YOUR OCCUPATION?:

Do you use tobacco? □Yes □No□Past use Do you drink alcohol?□No □Yes

Avg. # drinks per day _____

Do you use sunscreen? □None □Daily□Occasionally Do you have any other medical problems or conditions?

ADDITIONAL SYMPTOMS

Fever □ Yes□ No	Unintentional weight loss □ Yes □ No	Rash / itch □ Yes □ No
Chills □ Yes □ No	Shortness of breath □ Yes □ No	Joint pain □ Yes □ No
Fatigue □ Yes □ No	Nausea / vomiting □ Yes □ No	Swollen lymph nodes□ Yes □ No
Headache □ Yes □ No	Chronic cough □ Yes □ No	Easy bruising □ Yes □ No