Trillium Creek

HMT DERMATOLOGY MEDICAL HISTORY

Today's Date: _____ New Patient: _____ Established Patient (Appt. in last 3 years?):_____

Patient: _____ Date of Birth: _____ Age: _____

City: _____ State: _____

Who referred you (circle one)? Friend/Family Newspaper/Website Dr. _____ Other

Reason for today's skin condition **(circle ALL that apply)**:

Acne	Allergies	Growth /Spot	Hair Problems	Nail Problems	Rosacea	Infection
Eczema	Rash	Hives	Full Body Check	Psoriasis	Skin Tags	Other:_____

Height: _____ Weight: _____

Do you have now, or have you ever had, any of the following conditions?
(If so, please circle the ones that you have had)

Respiratory
Asthma
COPD
Tuberculosis
Wheezing

Muscular
Arthritis
Limited Motion

Endocrine
Diabetes
Hyperthyroid
Hypothyroid
Kidney Problems
High cholesterol

Cardiovascular
Atrial Fibrillation
Chest Pain
Coronary Artery Disease
High blood pressure
Mitral Valve Prolapse
Irregular heartbeat
Pacemaker
Phlebitis
Shortness of breath

Psychological
Anxiety
Depression

Gastrointestinal
Acid reflux
Colitis
Crohn's disease
GERD
IBS
Ulcerative Colitis

Other
Bone Marrow Transplantation
HIV/AIDS
Hearing loss
Seizures
Radiation treatment

Hepatitis A, B, or C
-What type? _____
-How was it treated and when? _____
-Are you in remission and if so how long?_____

Other Medical Conditions: _____
List any personal cancer(s), how and when they were treated: _____
_____

PATIENT ALERTS: (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Requires antibiotics prior to a surgical procedure
Rapid heart beat with epinephrine
Currently pregnant or trying to get pregnant

Past Surgical History: (Please circle all that apply and list the date of the procedure)

_____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
_____Mechanical Valve Replacement
_____Biological Valve Replacement
_____Heart Transplant
_____Joint Replacement, Knee (Right, Left, Bilateral)
_____Joint Replacement, Hip (Right, Left, Bilateral)
_____Joint replacement in last 2 years
_____Kidney Biopsy (Nephrectomy)
_____Kidney Removed (Right, Left)
_____Kidney Stone Removal
_____Kidney Transplant
_____Ovaries removed: Endometriosis
_____Ovaries removed: Cyst
_____Ovaries Removed: Ovarian Cancer
_____Prostate Removed: Prostate Cancer
_____Prostate Biopsy
_____TURP (Prostate Removal)
_____Spleen Removed
_____Testicles Removed (Right, Left, Bilateral)
_____Hysterectomy: Fibroids
_____Hysterectomy: Uterine Cancer

None

Other_____

Skin Disease History: (Circle all that apply)

Acne
Actinic Keratoses
Basal Cell Skin Cancer
Blistering Sunburns
Dry skin
Eczema
Flaking/Itchy scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

None

What would you consider your sun exposure to be? Minimal Moderate Excessive

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

Do you tan in a tanning salon? Yes No

List ALL Medications:

_____

_____

Allergies? _____ If so, please list: _____

_____

Do you take Aspirin Daily? _____

Occupation & Workplace: _____

Family Medical History:

Family history of cancer? _____ If yes, who and what type of cancer? _____

_____

Family history of melanoma? _____ If yes, who? _____

Family history of eczema? _____

Family history of psoriasis?_____

Family history of skin cancer? _____ If yes, who and what type of skin cancer? _____

_____

Patient Social History: (circle all that apply)

Cigarette Smoking

Currently Smokes

Has smoked in the past

Never smoked

Former smoker

Alcohol Use

None

Less than 1 drink per day

1-2 drinks per day

3 or more drinks per day