PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY FORM

Name_____ Date _____ Age _____ Sex _____ Ht _____ Wt _____
Referring Doctor_____ Primary Care Doctor _____
Do you have an advanced directive/living will? ☐Yes ☐No
Preferred pharmacy: ☐Yes _____ ☐No (will send to Concord Pharmacy in building)

Reason for today's visit:
History of today's problem(s):
Skin areas involved:
How long has the problem been present?
Was a biopsy done? ☐No ☐Yes Who did the biopsy? ☐Referring MD ☐Other_____
Any previous treatment? ☐No ☐Yes What was done and when?_____
Previous skin cancer? ☐No ☐Yes Previous Mohs surgery? ☐No ☐Yes_____

Check all that apply regarding today's problem: ☐None Apply
CHANGE IN: ☐Size ☐Color ☐Elevation ☐Hardness
HISTORY OF: ☐Bleeding ☐Tingling/itching ☐Pain ☐Ulceration ☐Infection ☐Occasional symptoms ☐Constant symptoms
RISK FACTORS: ☐X-ray treatments (not routine X-rays) ☐UV light treatments ☐Arsenic exposure ☐Immunosuppression

PLEASE LIST ALL MEDICATIONS, **DOSAGES, & FREQUENCY** (Including vitamins, herbs and supplements)

MEDICATION ALLERGIES: ☐None ☐ List with reaction:
LATEX ALLERGY: ☐Yes ☐No

Check ALL that apply regarding your overall health and add any other medical problems:

CARDIOVASCULAR
☐*Normal*
☐Artificial valve
☐Pacemaker
☐High blood pressure
☐Heart Attack (when?)
☐High Cholesterol
☐Bypass/other surgery
☐Mitral valve prolapse
☐Other heart problem

GASTROINTESTINAL
☐*Normal*
☐Stomach Ulcer
☐Colitis
☐Irritable bowel
☐Reflux

NEUROLOGICAL
☐*Normal*
☐Stroke
☐Seizures
☐Alzheimer's
☐Parkinson's

PSYCHIATRIC
☐*Normal*
☐Depression
☐Anxiety disorder
☐Other

BLOOD/LYMPH
☐*Normal*
☐Enlarged lymph nodes
☐Anemia
☐Bleeding problems

RESPIRATORY
☐*Normal*
☐Emphysema
☐Asthma

ENDOCRINE
☐*Normal*
☐Diabetes
☐Thyroid problem

SKIN
(besides skin cancer)
☐*Normal*
☐Poor/slow healing
☐Keloids

GENERAL
☐*Normal*
☐Fever/Weight loss

INFECTIONS
☐*Normal*
☐Hepatitis
☐HIV/AIDS
☐Tuberculosis
☐MRSA

MUSCULOSKELETAL
☐*Normal*
☐Arthritis
☐Fibromyalgia
☐Artificial joint – date installed:

HEAD/NECK
☐*Normal*
☐Hearing aid
☐Glaucoma
☐Plastic surgery

OTHER MEDICAL PROBLEMS: _____

_____

MAJOR ILLNESSES/HOSPITALIZATIONS: ☐none ☐List: _____

_____

FAMILY HISTORY: ☐Melanoma ☐Other skin cancers ☐Bleeding Problems
☐Other medical problems: _____

Occupation:_____ Marital status: ☐S ☐M ☐D ☐W
Do you wear: ☐Dentures ☐Glasses ☐Contacts
Smoking: ☐No ☐Former ☐Yes; packs per day?_____
Alcohol: ☐No ☐Social/occasional drinking Number of drinks/day _____
How many times have you had 5 (men) or 4 (women) or more drinks in a day in the past year? _____
Alcohol or drug problems/addictions: ☐No ☐Yes (please describe) _____
Have you had a flu shot in the past year? ☐No ☐Yes Have you ever had the pneumonia vaccine? ☐No ☐Yes