DERMATOLOGY
• OF NEW MEXICO •

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Medical History

Please Mark/Circle the following Positive Medical History

PAST MEDICAL HISTORY

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ BPH
- ❑ CVA/Stroke
- ❑ COPD/Emphysema
- ❑ CAD (coronary artery disease)
- ❑ Depression
- ❑ Diabetes
- ❑ Elevated Blood Pressure
- ❑ End Stage Renal Disease
- ❑ Epilepsy
- ❑ GERD (reflux)
- ❑ Hearing loss
- ❑ HIV/AIDs
- ❑ Hypercholesterolemia
- ❑ Hyperthyroidism (high thyroid)
- ❑ Hypothyroidism (low thyroid)
- ❑ Hepatitis
- ❑ Leukemia
- ❑ Lymphoma
- ❑ Lung Cancer
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ Prostate Cancer
- ❑ Radiation treatment
- ❑ Bone Marrow transplant
- ❑ Autoimmune disease
- ❑ Other

SKIN DISEASE

- ❑ Acne
- ❑ Actinic keratosis
- ❑ Asteatosis (Excessive Dry Skin)
- ❑ Basal cell carcinoma
- ❑ Dysplastic nevi (Precancerous moles/Atypical Moles)
- ❑ Eczema
- ❑ History of Asthma
- ❑ History of Hay Fever
- ❑ Melanoma
- ❑ Pruritus (Itchy) Scalp
- ❑ Psoriasis
- ❑ Squamous cell carcinoma
- ❑ Sunburn of Second degree
- ❑ Autoimmune skin rashes/disease
- ❑ Other

PAST SURGICAL HISTORY

Please note any past surgeries: ____________________

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OTHER QUESTIONS

Do you wear sunscreen? ❑ Yes ❑ No If yes, what SPF: ____________________

Do you tan in a salon? ❑ Yes ❑ No

FAMILY HISTORY

Do you have a family history melanoma? ❑ Yes ❑ No

If yes, which relative? ____________________

MEDICATIONS

Please list all medications and supplements you take – *please include the dose, and how many times taken daily – If needed, attach a separate sheet*

ALLERGIES

Please list allergies with reactions:

SOCIAL HISTORY

Smoking status: ❑ Non Smoker ❑ Former Smoker ❑ Current Smoker ❑ Other Tobacco

If you currently smoke, how much per day? ____________________

ALCOHOL HISTORY

Do you drink alcohol? ❑ Yes ❑ No

If yes, do you drink: ❑ <1 drink per day ❑ 1–2 drinks per day ❑ >3 drinks per day

OCCUPATION

What is your occupation and workplace? ____________________

If retired, what is your past occupation? ____________________

REVIEW OF SYSTEMS

Do you have problems with: ❑ healing ❑ scarring OR ❑ bleeding?

ALERTS: Please Mark the following

❑ Allergy to lidocaine
❑ Allergy to topical antibiotics
❑ Allergy to latex
❑ Artificial heart valve
❑ Artificial joints placed within the past 2 years
❑ Currently on blood thinner
  ❑ If so, what type ____________
❑ Defibrillator

❑ Pacemaker
❑ History of MRSA infection
❑ Premedication to procedures
❑ Rapid Heartbeat with epinephrine
❑ Currently pregnant or planning to get pregnant in the near future
❑ HIV/AIDs
❑ Hepatitis C