Patient Name: _____ Date of Birth: _____

PATIENT MEDICAL HISTORY		DETAILS
Asthma:	☐	_____
Diabetes:	☐	_____
Hepatitis:	☐	_____
Heart Disease:	☐	_____
High Blood Pressure:	☐	_____
HIV/AIDS:	☐	_____
Internal Cancer:	☐	_____
Seasonal Allergies:	☐	_____
Thyroid Disorder:	☐	_____
Clotting/Blood Disorders (Hemophilias)	☐	_____

SURGERY/HOSPITALIZATIONS:	DATE	ANESTHESIA COMPLICATIONS	NOTES

PATIENT SKIN HISTORY (please check all that apply)		TREATMENT	PHYSICIAN
ACTINIC KERATOSIS:	☐	_____	_____
BASAL CELL CARCINOMA:	☐	_____	_____
ECZEMA:	☐	_____	_____
MALIGNANT MELANOMA:	☐	_____	_____
PSORIASIS:	☐	_____	_____
SQUAMOUS CELL CARCINOMA:	☐	_____	_____
URTICARIA/HIVES:	☐	_____	_____

PATIENT FAMILY HISTORY (CHECK ALL THAT APPLY)

		Family Member(s)
Adopted:	☐	
Asthma/Allergies:	☐	_____
Diabetes :	☐	_____
Internal Cancer :	☐	_____
Malignant Melanoma :	☐	_____
Psoriasis:	☐	_____
Skin Cancer:	☐	_____
Skin Disease:	☐	_____

Allergies to Medications:

_____

_____

_____

_____

Alcohol Use: None ____ Socially ____ Daily_____

Illegal Drugs: Yes_____ No_____

History of STDs: Yes _____No _____

Is patient under Hospice Care? _____.

Have you experience a recent fall or a problem with gait or balance? Yes _____, No _____, N/A_____.

Patient Smoking History

Please check one:

☐ Current tobacco user

☐ Former smoker

☐ Never smoker

Please list all medications and doses:

_____

_____

_____

_____

_____

_____

_____

_____