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: ☐ ____

Other: ☐ ____

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 ______

Patient Smoking History

Please check one:

☐ Current tobacco non-user

☐ Current tobacco user

☐ Current smokeless tobacco user (chew, snuff)

☐ Former smoker started: ________________ ended: ________________

☐ Never smoker

Please list all medications and doses:

____

____

____

____

____

____

____

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