

PATIENT HEALTH RECORD

NAME OF PATIENT: LAST _____ FIRST _____ MIDDLE _____

DATE OF BIRTH _____

MEDICATIONS: (Include non-prescription medications, topical medications, supplements, and birth control)

ALLERGIES:

Medications _____

Topical medications/products (such as adhesive tape, antibiotic ointments, fragrance): _____

Latex (Gloves) Yes No

REASON FOR TODAY'S VISIT:

CURRENT AND PAST MEDICAL PROBLEMS:

Please elaborate on "Yes" answers in space provided or at end of section

Yes No Skin cancer (Basal cell carcinoma Squamous cell carcinoma Melanoma Unknown)

Yes No Abnormal moles (atypical or dysplastic nevi)

Yes No Skin disease (Eczema Psoriasis Acne Other _____)

Yes No Hayfever/allergies

Yes No Lung disease (Asthma Other _____)

Yes No Heart disease

Pacemaker

Valve replaced/repared

Coronary artery disease/blockage in arteries

Heart attack/myocardial infarction

Valve disease/murmur

Irregular heart beat/arrhythmia

Cardiac surgery/procedures _____

- Yes No High Blood Pressure/hypertension _____
 - Yes No Stomach or bowel disease _____
 - Yes No Liver disease _____
 - Yes No Kidney disease _____
 - Yes No Joint disease/arthritis _____
 - Yes No Artificial joints/implants _____
 - Yes No Diabetes _____
 - Yes No Stroke _____
 - Yes No Migraine headaches _____
 - Yes No Blood disorders (Bleeding disorder Blood clot Anemia Other _____)
 - Yes No Infectious diseases (Tuberculosis Hepatitis HIV Other _____)
 - Yes No Psychiatric disorder _____
 - Yes No Other _____
- Additional information on past or current health problems _____

FEMALE PATIENTS:

- Yes No Pregnant
- Yes No Planning to become pregnant
- Yes No Breastfeeding

FAMILY HISTORY: Please elaborate on “Yes” answers at end of section

- Unknown/adopted (skip to next section)
 - Yes No Skin Cancer (Basal cell carcinoma/Squamous cell carcinoma Melanoma)
 - Yes No Skin Diseases (Eczema Psoriasis Acne Other _____)
- Family members affected/details _____

SOCIAL & HEALTH HABITS:

- Tobacco use Never Past Current (packs per day _____)
- Sunscreen use Daily/almost always Sometimes/for specific activities Rarely Never
- Alcohol use Never Rarely Average number of alcoholic beverages per day _____
- Tanning bed use Never Past Current

SIGNATURE* _____ DATE _____

Patient Name _____ *Parent/Guardian/Other -- Relationship _____

*Parent/Guardian signature required for minors

For Physician Use/Reviewed by _____ Date _____