# ASSOCIATES IN DERMATOLOGY OF TRAVERSE CITY- MEDICAL HISTORY

Name: _____ Occupation: _____

DOB: ___/____/_____ Age: _____ Sex: _____ Referred by:_____

Primary Care Physician: _____

Reason for today's visit: _____ Area(s) of body? _____

How have you treated? _____ When was first occurrence? _____

**PAST MEDICAL HISTORY**: (circle all that apply)

| | | |
|---|---|---|
| Anxiety | Diabetes | Hypothyroidism (low) |
| Arthritis | End Stage Renal Disease | Leukemia |
| Asthma | GERD | Lung Cancer |
| Atrial Fibrillation | Hearing Loss | Lymphoma |
| Bone Marrow Transplant | Hepatitis | Pneumonia Vaccine |
| Breast Cancer | High Blood Pressure | Prostate Cancer |
| Colon Cancer | HIV/AIDS | Radiation Treatment |
| COPD | High Cholesterol | Seizures |
| Coronary Artery Disease | Hyperthyroidism (high) | Stroke |
| Depression | | NONE |

**PAST SURGICAL HISTORY:** (please list): NONE

_____

_____

_____

**SKIN DISEASE HISTORY:** (circle all that apply)

| | | |
|---|---|---|
| Acne | Dry Skin | Poison Ivy |
| Actinic Keratosis | Eczema | Precancerous Moles |
| Asthma | Flaking or Itchy Scalp | Psoriasis |
| Basal Cell Carcinoma | Hay Fever/Allergies | Squamous Cell Carcinoma |
| Blistering Sunburns | Melanoma | Cancer |
| Other: _____ | | NONE |

Do you wear sunscreen? YES NO If yes, what SPF? _____ Do you tan indoor/outdoor? YES NO

Do you have a family history of melanoma? YES NO If yes, which relative(s)? _____

**MEDICATIONS:** (Please list all current medications)

_____

_____

_____

**OVER→**

**ALLERGIES:** (please list all allergies to medications)

_____

_____

**SOCIAL HISTORY:**

Do you smoke? Yes__ No__ If yes, how much? _____ **If no**, have you smoked in the past? Yes__ No__

Do you use IV drugs? Yes___ No___ If yes, what type? _____ **If no**, have you used in the past? Yes__ No__

Do you drink alcohol? Yes___ No___ If yes, _____drinks per day/week/month

Do you have a family history of cancer (other than skin)? YES NO If yes, type of cancer(s)? _____

Which relative(s)? _____

**REVIEW OF SYSTEMS:** Do you **CURRENTLY** have any of the following? Circle **Y for YES** or **N for NO**

| | | | |
|---|---|---|---|
| **GENERAL:** | | | |
| Fever | Y N | **NEUROLOGICAL:** | |
| Weight Loss | Y N | Headaches | Y N |
| **HEENT:** | | Seizures | Y N |
| Blurred Vision | Y N | **RESPIRATORY:** | |
| Sore Throat | Y N | Chronic Cough | Y N |
| **ENDOCRINE:** | | Shortness of Breath | Y N |
| Thyroid Problems | Y N | Wheezing | Y N |
| **CARDIOVASCULAR:** | | **HEMATOLOGY:** | |
| Swelling of Extremities | Y N | Abnormal Bleeding | Y N |
| **GASTROINTESTINAL:** | | **INTEGUMENTARY:** | |
| Abdominal Pain | Y N | Bruising | Y N |
| Bloody Stool | Y N | Problems with Scarring | Y N |
| Bloody Urine | Y N | Rash | Y N |
| **MUSCULOSKELETAL:** | | **PSYCHIATRIC:** | |
| Joint Pain | Y N | Anxiety | Y N |
| Muscle Pain or Weakness | Y N | Depression | Y N |

**ALERTS:** (circle all that apply)

| | |
|---|---|
| Allergy to Adhesive | Allergy to Lidocaine |
| Allergy to Topical Antibiotics | Artificial Heart Valve |
| Artificial Joint Replacement | Blood Thinners |
| Defibrillator | MRSA |
| Pacemaker | Pregnant or trying to get pregnant |
| Latex Allergy | Breastfeeding |
| Rapid heart with epinephrine | |
| Require antibiotics prior to a dental/surgical procedure | Reason: _____ |

Race: _____ or DECLINE Ethnic Group: _____ or DECLINE

Preferred Pharmacy Name/Location: _____

Preferred Language: ENGLISH or Other: _____

PATIENT SIGNATURE: _____

Staff Initials_____