

Pharmacy ☐ HT ☐
 Photo ☐ WT ☐
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Medical History



**MID-COLUMBIA
DERMATOLOGY**

Time:

Provider:

Ins:

Room:

Appointment Date: _____ Patient Name: _____ Date of Birth: _____

Reason(s) for today's visit:

Problem 1

Description of problem:

Location of problem:

How long have you had the problem:

Previous treatment for the problem:

Were the previous treatments effective:

Problem 2

Description of problem:

Location of problem:

How long have you had the problem:

Previous treatment for the problem:

Were the previous treatments effective:

Are you currently Pregnant or Breastfeeding: ☐ Yes ☐ No

Last Menstrual Period: _____

Preferred Pharmacy: _____ **City:** _____

Do you have any of the following: ☐ Pacemaker ☐ Artificial joints or heart valve

Medications: List all current prescription or over the counter medication/vitamins/supplements you are taking:

Allergies: List all allergies and reactions if known:

Current List of Doctors:

Past Medical History

Select any of the following medical conditions you have had:

- | | | |
|---|---|---|
| ☐ Anxiety | ☐ Coronary Artery Disease | ☐ IBD/Crohn's/Ulcerative Colitis |
| ☐ Arthritis | ☐ Depression | ☐ Kidney Problems |
| ☐ Asthma | ☒ Diabetes | ☐ Leukemia |
| ☐ Atrial Fibrillation | ☐ End Stage Renal Disease | ☐ Lupus |
| ☐ Cancer: Breast | ☐ GERD | ☐ Lymphoma |
| ☐ Cancer: Colon | ☐ Hearing Loss | ☐ Multiple Sclerosis |
| ☐ Cancer: Lung | ☐ Hepatitis: A, B or C | ☐ Radiation Treatment |
| ☐ Cancer: Prostate | ☐ Hypertension | ☐ Seizures |
| ☐ Cancer: Other _____ | ☐ HIV / AIDS | ☐ Stroke |
| ☐ Congestive Heart Failure | ☐ Hypercholesterolemia | ☐ NONE |
| ☐ COPD | ☐ Hyperthyroidism/Hypothyroidism | ☐ Other _____ |

Past Surgical History

Have you had any surgeries on the following organs?

- | | | |
|--|---|--|
| ☐ Appendix (Appendectomy) | ☐ Joint Replacement: Hip (Right, Left, Bilateral) | ☐ Prostate (Prostatectomy): Prostate Biopsy |
| ☐ Bladder (Cystectomy) | ☐ Joint Replacement: Knee (Right, Left, Bilateral) | ☐ Prostate (Prostatectomy): Prostate Cancer |
| ☐ Breast: Breast Biopsy | ☐ Kidney: Kidney Biopsy | ☐ Prostate (Prostatectomy): TURP |
| ☐ Breast: Lumpectomy (Right, Left, Bilateral) | ☐ Kidney: Kidney Stone Removal | ☐ Rectum: APR |
| ☐ Colon (Colectomy): Colon Cancer Resection | ☐ Kidney: Kidney Transplant | ☐ Rectum: Low Anterior Resection |
| ☐ Colon (Colectomy): Diverticulitis | ☐ Kidney: Nephrectomy | ☐ Skin: Basal Cell Carcinoma |
| ☐ Colon (Colectomy): Inflammatory Bowel Disease | ☐ Liver: Hepatectomy | ☐ Skin: Melanoma |
| ☐ Colon: Colostomy | ☐ Liver: Liver Transplant | ☐ Skin: Squamous Cell Carcinoma |
| ☐ Gallbladder (Cholecystectomy) | ☐ Mastectomy (Right, Left, Bilateral) | ☐ Spleen (Splenectomy) |
| ☐ Heart: Coronary Artery Bypass Surgery | ☐ Ovaries (Oophorectomy): Endometriosis | ☐ Testicles (Orchiectomy) |
| ☐ Heart: Heart Transplant | ☐ Ovaries (Oophorectomy): Ovarian Cancer | ☐ Uterus (Hysterectomy): Fibroids |
| ☐ Heart: Mechanical Valve Replacement | ☐ Ovaries (Oophorectomy): Ovarian Cyst | ☐ Uterus (Hysterectomy): Uterine Cancer |
| ☐ Heart: PTCA | ☐ Ovaries: Tubal Ligation | ☐ Uterus (Hysterectomy): Cervical Cancer |
| | ☐ Pancreas: Pancreatectomy | ☐ NONE |
| | | ☐ Other _____ |

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Atypical Nevus
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ NONE
- ☐ Other _____

Do you wear Sunscreen?

☐ Yes ☐ No

If yes, what SPF? _____

Do you tan in a tanning salon?

☐ Yes ☐ No

Last Full Body Skin Exam: _____

Social History

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:

• mm/dd/yyyy _____

Quit Smoking:

• mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Occupation: _____

Family History

Has anyone in your family had the following problems:

- | | |
|--|-------------------|
| ☐ Basal Cell Skin Cancer | If yes, who _____ |
| ☐ Squamous Cell Skin Cancer | If yes, who _____ |
| ☐ Melanoma | If yes, who _____ |
| ☐ Acne | If yes, who _____ |
| ☐ Eczema | If yes, who _____ |
| ☐ Psoriasis | If yes, who _____ |
| ☐ Lupus | If yes, who _____ |
| ☐ IBD/Crohn's/ Ulcerative Colitis | If yes, who _____ |

Review of Systems

Are you having any of these skin symptoms:

- | | |
|--|---|
| ☐ Excessive Bleeding | ☐ Poor wound healing |
| ☐ Sensitivity to sun | ☐ Bruise easily |
| ☐ Problems with hair | ☐ Keloid scarring |
| ☐ Problems with nails | ☐ Skin sensitivity |
| ☐ Allergy topical antibiotics | ☐ Allergy to Band-Aids |
| ☐ Sun exposure History: | Mild Moderate Severe |

Are you experiencing any of the following:

- ☐ Fever/chills
- ☐ Trouble sleeping because of a skin problem
- ☐ Restricted activity because of a skin problem
- ☐ Itch scale: 1 – 10

65 >: Medical decision maker or POA? ☐ Yes ☐ No

Patient Signature: _____

Date: _____