| | | MEDICA | L HISTORY | QUESTIO | N | NAIRE |
|---|--|---|--|-----------------------------------|---|--|
| Name: | | | DOB: | | | |
| Reason for To | day's Visit: | 1 | | | | |
| | | LIST | OF CURREN | T MEDICAT | ION | IS |
| Lis | t all prescripti | ons including dermatologi (Use the backside of th | | | | ications, vitamins, herbals and creams. |
| | Madiaatia | · | из тогит и тоге зрас | te is rieeded to list a | 111 01 | your medications) |
| Medication (Brand and Generic Name) | | | ose How Often Do You Take the Medication | | | |
| (Brana and Generie Name) | | | | | | |
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| | | DED | SONAL MED | OICAL HISTO |)DV | |
| | (Please | | | | | ed with in the past or present) |
| Dermatological Cor | nditions: | ☐ Melanoma ☐ Basal C | Cell Carcinoma | ☐ Squamous Cell (| Carcii | noma Actinic Keratosis Eczema |
| Other Medical Conditions: | | ☐ HIV ☐ High Blood | | Pressure | ressure Blood Disorder, excessive bleeding or easy bruising | |
| | | ☐ Hepatitis C/Liver Disease ☐ Artificial He | | art Valve | | |
| | | □Heart (or heart murmur) | rt (or heart murmur) | | | □ MMR |
| List any other r | nedical prob | lems that other docto | rs have diagno | sed: | | |
| | <u>-</u> | | | | | |
| Are you allorgi | to any mod | lications? If you place | a list balawı | 1 | | EEMALES ONLY. |
| Are you allergic to any medications? If yes, please list below: | | | | FEMALES ONLY: | | |
| | | | | Are you Pregnant? ☐ Yes ☐ No | | |
| | | | | Are you Breastfeeding? ☐ Yes ☐ No | | |
| Surgeries (include previous dermatological surgeries | | | | Other hospitalizations | | |
| Year | Reason | | | Year | | Reason |
| | | | | | | |
| | | | | | | |
| | | | EAMTIVI | LICTORY | | |
| Do you have a | family histor | ry of Melanoma? □Ye | FAMILY I | If yes, which | fam | ilv member: |
| Do you nave a | | y or ricianoma. | .5 = 110 | 21 yes, which | | |
| | | | SOCIAL I | HISTORY | | |
| Skin Type | □ always b | ourn, never tan | | Sun Exposu | re | |
| ,,,,, | □ sometim | nes burn, but always ta | an | - | | ☐minimal sun-exposure throughout the year |
| | □ never burn, always tan | | | | | ☐moderate sun-exposure throughout the year |
| | □ moderat | tely pigmented skin | | | | □excessive sun-exposure throughout the year |
| | | gmented skin | | | | |
| Tobacco | Are you a | * | | Sun Safety | | Have you ever had a blistering sunburn? |
| | ☐ Current Smoker ☐ Former Smoker ☐ Never | | | | | □Yes□No |
| | | t smoker': How mar | ny cigarettes | | | If yes, how many? ☐ one ☐ two ☐ three or more |
| | □ 5 or le | noke per day? ess □ 6 – 1 | 10 cigarettes | | | Sunscreen use: |
| | | | 30 cigarettes | | | □intermittent □occasional □regularly □none Do you use tanning beds? |
| | | ☐ 31 or more cigarett | es | | | □Yes □ No |

| LIST OF CURRENT MEDICATIONS (CONTINUED) | | | | | | | |
|---|------|--------------------------------------|--|--|--|--|--|
| Medication (Brand and Generic Name) | Dose | How Often Do You Take the Medication | | | | | |
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