MOBILE DERMATOLOGY MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____ Date filled out: _____

Preferred name: _____ Preferred phone number for test results: _____

Primary care physician: _____ Preferred Pharmacy(Name/#): _____

Emergency Contact: Name: _____ Phone number: _____

Email address (to activate your patient portal): _____

»***Because of privacy concerns, we cannot discuss your medical history with others (including family members) without your permission***. Is it ok to discuss your diagnosis and treatment with a family member/friend?

❑YES ❑NO If yes, please list the name and relationship: _____

»***Do you now have, or have you ever been diagnosed with any of the following conditions: (CHECK IF YES)***

❑ Anxiety	❑ Diabetes	❑ Leukemia
❑ Arthritis	❑ End stage kidney disease	❑ Lung cancer
❑ Artificial Joint	❑ Heartburn/Acid reflux	❑ Lymphoma
❑ Asthma	❑ Hearing loss	❑ Pacemaker
❑ Atrial fibrillation	❑ Hepatitis B /C (circle one)	❑ Defibrillator
❑ Breast cancer	❑ High blood pressure	❑ Prostate cancer (males)
❑ Colon cancer	❑ HIV / AIDS	❑ Seizures
❑ COPD	❑ High cholesterol	❑ Stroke
❑ Coronary artery disease	❑ Hyperthyroid (high)	❑ Valve replacement (heart)
❑ Depression	❑ Hypothyroid (low)	❑ ***None of these***

»***Other Medical Problems/Surgeries***: _____

»***Gynecology: (Females only):*** Pregnant or planning pregnancy ❑YES ❑NO ***Due Date:*** _____

»Do you have any problems with your ***immune system***? ❑YES ❑NO

» Do you have a history of developing ***thick scars/keloids***? ❑YES ❑NO

»Have you ever had ***skin cancer***? ❑YES ❑NO ❑Not Sure
If yes, check what type(s): ❑Basal Cell ❑ Squamous Cell ❑Melanoma ❑Not sure

»***Family History:*** Do any of your ***first degree relatives*** *(Parents, siblings or children)* have a history of:
Melanoma? ❑YES Relationship: ❑Mother ❑Father ❑Brother ❑Sister ❑Son ❑Daughter

»***Social History:***
Do you use or have you used tanning beds? ❑YES ❑NO
Do you drink alcohol? ❑YES ❑NO----------*If yes*, _____drinks per day
Do you smoke? ❑YES ❑Quit ❑NO --------*If yes*, _____packs per day

»LIST ANY MEDICATION ALLERGIES: ❑No allergies

_____

»MEDICATIONS: ❑No medications
•*If you have a medication list, please give it to the receptionist to be copied instead of writing them down.*
•*If needed, can we obtain a list of your medications from your pharmacy?:* ❑YES ❑NO

_____

_____