Dermatology Patient Health History Form

Allergies:
- ☐ None
- ☐ Latex
- ☐ Band-Aid/Adhesive
- ☐ Medication Allergies (List Below)

General/Social Information:
Any nicotine in the last 12 months? ☐ Yes ☐ No
☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Ecig ☐ Gum/patch

Are you a former smoker? ☐ Yes ☐No

If yes, when did you quit? ____________________

Do you drink alcohol? ☐ Yes ☐ No

Do you use illicit drugs (cocaine, marijuana, methamphetamines)? ☐ Yes ☐ No

Are you pregnant or nursing? ☐ Yes ☐ No

Current Occupation/Employment (Please circle)

Retired Disabled Working as ________________

Personal History of Skin Cancer? ☐ Yes ☐ No

If so, which type? ____________________

If so, where was it? ____________________

Family History of Skin Cancer? ☐ Yes ☐ No

If so, which type? ____________________

Tanning Bed Use? ☐ Yes ☐ No

Sunscreen Use? ☐ Yes ☐ No

Please List All Current Medications

Prescription and Over The Counter Drugs:

Do you take any blood thinners? ☐ Yes ☐ No

If so, which one(s)? ____________________

Please List Current Health/Medical Problems

Please List Previous Surgeries

Pacemaker?	☐ Yes	☐ No
Stents or Valves?	☐ Yes	☐ No
Joint Replacement?	☐ Yes	☐ No
Organ Transplant?	☐ Yes	☐ No

If so, when? ____________________