MEDICAL HISTORY

Patient: _____ M___ F___ Married/Single AGE_____

Reason for today's visit: _____
How long has condition been present: _____
Have you been treated for this before? [ ] Yes [ ] No When (approximately)?_____
Are you allergic to any medications? [ ] Yes [ ] No If yes please list: _____
_____

List all medications you are currently taking including birth control, vitamins and social drugs:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you have now, or have you ever had diseases or conditions related to: (please check all that apply)

Yes	No		Yes	No		Yes	No	
		Allergies, environmental			Chest pain, palpitations			Hormonal, diabetes, thyriod
		Allergies, medication			Stomach pain, dark stool,			Irregular menstrual cycles
		Allergies, tape-adhesives			Painful or frequent urination			Skin lesions or rash
		Weight loss, fatigue, fevers			Bruising or painful lumps			Immunologic
		Eye problems,visual changes			Weakness or headaches			Cancers
		Problems hearing,sore throat			Depression or anxiety			Poor healing (scarring/long healing)
		Breathing problems, cough			Bone or joint pain, muscle aches			Surgery

An unchecked box indicates that you do not; nor have ever had a disease or condition related to the above

IF YES TO ANY ABOVE, PLEASE EXPLAIN: _____
_____

PERSONAL HISTORY OF MELANOMA OR OTHER SKIN CONDITION: [ ] YES [ ] NO (IF YES, PLEASE EXPLAIN)
_____
Do you have a history of: multiple sunburns or significant sun exposure associated with work/recreation [ ] Yes [ ] No
When you are exposed to the sun, do you: [ ] Tan only [ ] Tan and burn [ ] Burn
Occupation:_____
Do you drink alcohol? [ ] Yes [ ] No Do you smoke? [ ] Yes [ ] No
Have you had or have you been exposed to HIV (AIDS), sexually transmitted diseases or Hepatitis? [ ] Yes [ ] No
Have you ever had dental anesthesia (Novocaine)? [ ] Yes [ ] No Any bad reaction [ ] Yes [ ] No
List any other disease or condition we should know about_____
(Women) Are you pregnant, breast feeding or considering having children within the next year? [ ] Yes [ ] No

FAMILY HISTORY (IF YES, PLEASE GIVE RELATIONSHIP)
Any family history of melanoma? [ ] Yes [ ] No Other types of skin cancers? [ ] Yes [ ] No (IF YES, PLEASE EXPLAIN)
_____
Other types of cancer? [ ] Yes [ ] No Other conditions or skin diseases [ ] Yes [ ] No (IF YES, PLEASE EXPLAIN)

Patient/guardian Signature: _____ Date:_____

Physician Signature: _____ Date: _____