MADISON MEDICAL

Dermatology Medical History

Date: _____ Email: _____

Name: _____ Name you like to be called?_____

Name/relationship of person completing this form (if different): _____

Best number to reach you: _____ Occupation: _____

Primary Physcian: _____ Referring Physician: _____

Allergies (please include medications, food, etc. and the reaction)

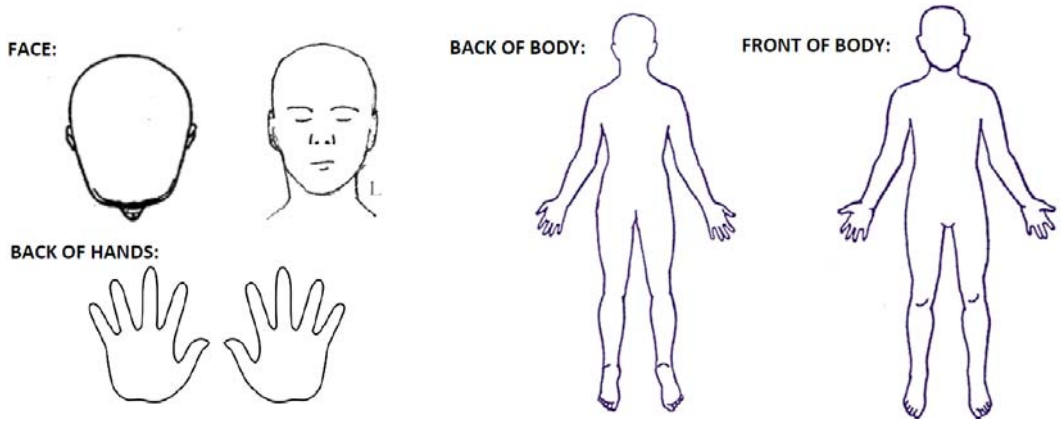
_____

Reason for appointment (we only have time for one concern per visit)

_____

Location on body:_____ Side of body: ☐ Left ☐ Right

**For paper forms only, please color/shade in all areas involved:*



When did you first notice the concern? _____

What things make it better?_____ worse?_____ _____

Has the lesion/area ever (check all that apply) ☐bled ☐itch ☐grown ☐sting/burn/pain ☐discomfort

☐changed in apperance ☐caused concern Other:_____

Questions for your doctor today?_____

Previous skin isses/concerns (treated or untreated):_____

Do you now have or have had any of the following (if yes, please check box & explain):

	YES	NO		YES	NO		YES	NO
Stroke	☐	☐	Blood Clots	☐	☐	Diabetes	☐	☐
Heart Attack/Valve Repair	☐	☐	HIV/AIDS	☐	☐	Hepatitis/Liver Disease	☐	☐
Cancer (except skin cancer)	☐	☐	Thyroid Problems	☐	☐	Other:_____		

(Explain)_____

In the past 2 weeks, are you having any new symptoms ☐Fever ☐Weakness ☐Nausea/Vomiting ☐Muscle/Bone Pain ☐None of these Other: _____

Explain any 'yes' answers: _____

Have you ever had skin cancer? ☐yes ☐no If yes, please explain:_____

Family history of skin cancer? ☐yes ☐no If yes, please explain:_____

History of eczema/sensitive skin? ☐yes ☐no History of atypical moles? ☐yes ☐no

Current Medications (please list all – including non-prescriptions/supplements):

_____

WOMEN ONLY: Are you pregnant or could you be pregnant? ☐yes ☐no Are you breastfeeding? ☐yes ☐no

PATIENT SIGNATURE (TYPE OR SIGN)_____ **DATE** _____

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