Scholes Dermatology- Medical History

Name____ Date of Birth_________________________

Medical History: Do you now have (or have had in the past) and the following conditions? Please check all that apply:

- o Anxiety
- o Arthritis (Osteo)
- o Arthritis (RA)
- o Asthma
- o Atrial Fibrillation/ Irregular Heartbeat
- o Benign prostatic hyperplasia
- o Coronary arteriosclerosis (Heart Disease)
- o COPD
- o Depression
- o Diabetes
- o End stage renal disease
- o Epilepsy
- o Gastric Reflux (GERD)
- o Hypertenion
- o Hearing Loss
- o Hepatitis Type______
- o HIV/AIDS
- o High Cholesterol
- o Leukemia
- o Lymphoma
- o Lung Cancer
- o Breast Cancer
- o Colon Cancer
- o Prostate Cancer
- o Radiation Treatment
- o Seizures
- o Stroke
- o Thyroid
- o Transplant of bone marrow
- o Other disease not listed __________________________

Surgical History: Please check all that apply to you:

- **o No Previous Surgeries**
- o Appendix
- o Bladder Removal
- o Breast Biopsy
- o Breast Lumpectomy (Left)
- o Breast Lumpectomy (Right)
- o Breast Mastecotmy (Left)
- o Breast Mastectomy (Right)
- o Colon Surgery (Cancer)
- o Colon Surgery (Diverticulitis)
- o Colon Surgery (UC/Crohn)
- o Gall Badder
- o Heart Bypass (CABG)
- o Heart Stent
- o Heart Transplant
- o Heart Valve (Mechanical)
- o Heart Valve (biological)
- o Heart: PTCA
- o Hip Replacement (Left)
- o Hip Replacement (Right)
- o Knee Replacement (Left)
- o Knee Replacement (Right)
- o Kidney Biopsy
- o Kidney Transplant
- o Liver Transplant
- o Liver Shunt
- o Prostate Biopsy
- o Prostate Cancer
- o Prostate TURP
- o Oophorectomy
- o Rectum Resection
- o Skin Biopsy
- o Melanoma
- o Spleen (Splenectomy)
- o Testicles (Orchiectomy)
- o Hysterectomy (Fibroids)
- o Hysterectomy (Uterine Cancer)
- o Hysterectomy (Cervical Cancer)
- o Other surgeries not listed _______________________

Skin Disease History: Please check all that apply to you:

- o Acne
- o Actinic Keratoses
- o Posion Ivy
- o Dry Skin
- o Eczema
- o Flaking or Itchy Scalp
- o Hay fever/ Allergies
- o Asthma
- o Melanoma
- o Psoriasis
- o BCC-Where?___________ _
- o SCC-Where?____________ _
- o Sunburn of second degree (Blisters)

- o Other skin problems not listed:____

Do you wear sunscreen? Yes No What SPF? ______

Do you tan in a tanning salon? Yes No

Do you have a family history of Skin Cancer? Who?______________________________

Does anyone in your family have a history of Melanoma? Who?______________________________

Do you get your flu shot year? Yes No **If over 66- Have you had your Pnemonia Vaccine?** Yes No

Do you have a living Will? Yes NO

Do you have a health care proxy in the event you are unable to make your own medical decisions? YES NO

Current Medications: Check here_____ if you take no medications.

____________________	____________________	____________________
____________________	____________________	____________________

Allergies to Medications: Please list any medications to which you are allergic: NONE

____________________	____________________	____________________
____________________	____________________	____________________

Which pharmacy do you use? ________________________________ City________________________

Social History:

Occupation: ____

PRIMARY DOCTOR:____

Smoking History: Please check one of the following:

- ☐ Never smoked
- ☐ Current every day smoker- **Cigarettes/ E-Cig/Vape**
- ☐ Chewing Tobacco
- ☐ Current occasional smoker
- ☐ Former smoker

Alcohol history: Please check one of the following:

- ☐ None
- ☐ Less than one drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

Female Patients:

Are you pregnant? Yes No Due date: ______________________

Are you breast-feeding Yes No