REHLEN • BARTLOW • GOODMAN•
BARON • PASSERO • SAEDLER • PARSA
ENGLAND • COTTRELL • NURSE • AMY

PATIENT HISTORY

PATIENT NAME: ______ AGE: ______ DATE OF BIRTH: ______ DATE: ______

SEX: M F MARITAL STATUS: S M D W BIRTHPLACE: ______ OCCUPATION: ______

ALLERGIES: ______ CURRENT MEDICATIONS: ______

PAST FAMILY HISTORY: ______ SOCIAL HISTORY: ______

PAST FAMILY SKIN CANCERS: ______ DO YOU SMOKE: Y N HOW MUCH/DAY: ______

PAST MEDICAL CONDITIONS: ______ DRINK ALCOHOL: Y N HOW MUCH/DAY: ______

PAST GENETIC DISEASES: ______ TAKE DRUGS: Y N WHAT KIND: ______

REVIEW OF SYSTEMS: HAVE YOU HAD ANY PROBLEMS WITH ANY OF THE FOLLOWING AREAS:

	NORMAL	ABNORMAL	(EXPLAIN, IF ABNORMAL)
EYES:			
EARS/NOSE/THROAT/MOUTH			
HEART/CARDIOVASCULAR			
LUNGS/RESPIRATORY			
STOMACH/BOWELS/GI			
KIDNEYS/GU			
ARTHRITIS/MUSCLES/JOINTS			
HEADACHES/SEIZURES/NEURO			
PSYCHOLOGICAL			
THYROID/DIABETES/ENDO			
BLOOD/BLEEDING/LYMPH			
ALLERGIC/IMMUNOLOGIC			
SKIN			

WHEN YOU ARE EXPOSED TO THE SUN DO YOU: TAN TAN AND BURN BURN

HAVE YOU EVER HAD SKIN CANCER? YES NO

WHAT KIND/HOW MANY? BASAL #______ SQUAMOUS #______ MELANOMA #______ WHEN? ______

PAST MEDICAL TESTS (BLOOD, BIOPSIES, X-RAYS, ETC): ______

LIST ANY OTHER DISEASES OR CONDITIONS WE SHOULD KNOW ABOUT: ______

LIST SURGICAL PROCEDURES YOU HAVE HAD: ______

I certify that I have completely disclosed my medical history and, to the best of my knowledge, have not withheld any medical information from this form.

______ Patient's/Parent or Guardian Signature

______ Date