

COASTALDERMATOLOGY Medical History

Patient Name: _____

Past Medical History: (please circle all that apply) NONE

- | | | |
|-------------------------|-------------------------|---------------------|
| Anxiety | Depression | Thyroid Problems |
| Arthritis | Diabetes | (Hypo or Hyper) |
| Asthma | End Stage Renal Disease | Leukemia |
| Atrial fibrillation | GERD | Lung Cancer |
| Bone Marrow | Hearing Loss | Lymphoma |
| Transplantation | Hepatitis | Prostate Cancer |
| Breast Cancer | High Blood pressure | Radiation Treatment |
| Colon Cancer | HIV/AIDS | Seizures |
| COPD | High Cholesterol | Stroke |
| Coronary Artery Disease | | |

Other _____

Past Surgical History: (please circle all that apply) NONE

- | | |
|--------------------------------------------------|--------------------------------------------|
| Appendix Removed | |
| Bladder Removed | Joint Replacement within last 2 years |
| Mastectomy (Right, Left, Bilateral) | Kidney Biopsy (Nephrectomy) |
| Lumpectomy (Right, Left, Bilateral) | Kidney Removed (Right, Left) |
| Breast Biopsy (Right, Left, Bilateral) | Kidney Stone Removal |
| Breast Reduction | Kidney Transplant |
| Breast Implants | Ovaries Removed: Endometriosis |
| Colectomy: Colon Cancer Resection | Ovaries Removed: Cyst |
| Colectomy: Diverticulitis | Ovaries Removed: Ovarian Cancer |
| Colectomy: IBD | Prostate Removed: Prostate Cancer |
| Gallbladder Removed | Prostate Biopsy |
| Coronary Artery Bypass | TURP (Prostate Removal) |
| Mechanical Valve Replacement | Spleen Removed |
| Biological Valve Replacement | Testicles Removed (Right, Left, Bilateral) |
| Heart Transplant | Hysterectomy: Fibroids |
| Joint Replacement, Knee (Right, Left, Bilateral) | Hysterectomy: Uterine Cancer |
| Joint Replacement, Hip (Right, Left, Bilateral) | |

Other _____

ALERTS: (please circle all that apply)

- | | |
|----------------------------------------------|-------------------------------------------------------------|
| Allergy to Adhesive | MRSA |
| Allergy to lidocaine | Pacemaker |
| Allergy to topical antibiotics | Require antibiotics prior to a surgical or dental procedure |
| Artificial heart valve | Rapid heart beat with epinephrine |
| Artificial joint replacement in last 2 years | Pregnant or currently trying to get pregnant |
| Blood thinners | |
| Defibrillator | |

COASTALDERMATOLOGY Medical History

Skin Disease History: (please circle all that apply)

NONE

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns

Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma

Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin
Cancer

Other _____

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)?

Do you wear Sunscreen? Yes No

If yes, what SPF?

Do you tan in a tanning salon? Yes No

Medications: (Please enter all current medications)

Allergies: (Please enter all allergies)

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:

EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Preferred Language:

English
Spanish
Other: _____

Race:

White
Black/African America
Asian
American Indian or
Native Alaskan
Other: _____

Ethnic Group:

Non-Hispanic/Latino
Hispanic/Latino

Preferred Pharmacy: _____ **Phone #:** _____

Address: _____ **City, State & Zip:** _____