DERMATOLOGY ASSOCIATES of Siouxland, PC

MRN: ________________

Medical History Form

Patient Name: ____ Date: _____/_____/_____
Date of Birth: _____/_____/_____ Age: _____ Sex: _____ Employer: ____________________
Referring Doctor________________________ Family Physician: ________________________
Reason for visit: ____
Location of problem: ________________________________ Date of onset: _____/_____/_____
Name (and city) of your pharmacy: ____

Past Medical History: (please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation (irregular heartbeat)
- ☐ BPH
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other ______________________
- ☐ None

Past Surgical History: (please check all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Both)
- ☐ Lumpectomy (Right, Left, Both)
- ☐ Breast Biopsy (Right, Left, Both)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee (Right, Left, Both)
- ☐ Joint Replacement, Hip (Right, Left, Both)
- ☐ Joint Replacement within last 2 years
- ☐ Kidney Biopsy
- ☐ Kidney Removed (Right, Left, Both)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Both)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Other ________________________
- ☐ None

Skin Disease History: (please check all that apply)

- ☐ 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
- ☐ None
- ☐ Other

Do you wear Sunscreen? ☐Yes ☐No
If yes, what SPF? ___________
Do you tan in a tanning salon? ☐Yes ☐No

Family history of Melanoma:
Do you have a family history of Melanoma? ☐Yes ☐No
If yes, which relative(s)?
____
Any other family history:

Medications: (Please enter all current prescriptions medications, OTC vitamins and herbals--if you have a written list, please provide list to staff for copying)

1)__________________ 2)__________________ 3) __________________ 4) __________________
5)__________________ 6)__________________ 7) __________________ 8) __________________
9)__________________10)__________________11) __________________ 12) __________________
13)__________________ 14)__________________ 15) __________________ 16) __________________

Allergies: (Please enter all allergies and specify type of reaction)

1)____ 2)____
3)____ 4)____

Social History: (Please check all that apply)

Cigarette Smoking:
- ☐ Never smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily

Sexual History:
- ☐ Not sexually active
- ☐ Sexually active with one partner
- ☐ Sexually active with more than one partner
- ☐ Same sex partner

Illicit Drug Use:
- ☐ Drug Use
- ☐ IV Drug Use

Alcohol Use:
- ☐ Alcohol: none
- ☐ Alcohol: less than 1 drink a day
- ☐ Alcohol: 1-2 drinks a day
- ☐ Alcohol: 3 or more drinks a day

Safety:
- ☐ I feel safe at home.
- ☐ I do not feel safe at home.

Other____

Females Only: Last menstrual period date: _____/_____/_____
Are your menstrual periods regular (27-29 days) every month? ☐Yes ☐No
Are you currently taking birth control pills? ☐Yes ☐No
Are you planning, possibly or currently pregnant? ☐Yes ☐No
Are you currently breastfeeding ☐Yes ☐No