MOUNTAIN LAUREL DERMATOLOGY

# Follow Up Patient Medical History

**Patient**:_____ **Date of Birth**:_____

**Skin Disease History**: (Please circle all that apply)

| | | |
|---|---|---|
| Acne | Dry Skin | Poison Ivy |
| A.K.'s (Precancers) | Eczema | Precancerous Moles |
| Asthma | Flaking/Itchy Scalp | Psoriasis |
| Basal Cell Cancer | Hay Fever/Allergies | Squamous Cell Skin Cancer |
| | | Other: |
| Blistering Sunburns | Melanoma | _____ |

**Do you wear Sunscreen**? : Yes or No
If Yes, what SPF? _____

**Do you currently tan in a tanning salon**? Yes or NO
**Have you ever tanned in a tanning salon**? Yes or NO
**Do you have a family history of melanoma**? Yes or No
If Yes, what relative(s)?_____

**Allergies**: (Please enter **all allergies, including medication allergies**, and describe what kind of reaction you have/had.)

_____
_____

**Social History: (Please Circle All that Apply)**
**Smoking Status**:

| | |
|---|---|
| Current Every Day Smoker | Former Smoker |
| Current Some Day Smoker | Never Smoker |

**Do you drink alcohol**? Yes or No
If Yes, how many drinks per day? _____

**Have your received a flu shot this year**? Yes or No
If Yes, when was the approximate date? _____

**Have you received a Pneumonia vaccination**? Yes or No

**Have you received a Shingles vaccination**? Yes or No

**Flip to the other side to continue**

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**Are you pregnant or planning a pregnancy?** **Yes** **No** **Not Applicable**

**Pharmacy Name**:_____ **Location:**_____

**Current Medications**: (Attach Additional Page if Necessary)

| **Medication Name** | **Strength** | **Dosage** |
|---|---|---|
| Example: *Ibuprofen* | *200mg* | *2 tablets every 8 hours* |
| | | |
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| | | |

**Are there any other changes to your medical history that we should know about**?

_____

_____ _____

**Patient or Authorized Representative Signature** **Date**