MOUNTAIN LAUREL DERMATOLOGY

New Patient Medical History

Turn page to continue

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

Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation (Irregular heartbeat)
Bone Marrow Transplant
BPH
Colon Cancer
Fibroids
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hepatitis
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Other: (Please Specify) _____
Hearing Loss
Breast Cancer

Past Surgical History: (Please Circle All that Apply)

Appendectomy
Bladder Cystectomy
Breast:
Mastectomy (R,L,Both?)
Lumpectomy (R,L,Both?)
Breast Biopsy
Colon:
Colon Cancer Resection
Diverticulitis
IBD
Colostomy
Gallbladder Removal
Heart:
Coronary Artery Bypass
Balloon Angioplasty
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement:
Knee (R,L,Both?)
Hip (R,L,Both?)
Kidney:
Kidney Biopsy
Nephrectomy
Kidney Stone Removal
Kidney Transplant
Liver:
Shunt
Transplant
Hepatectomy
Ovaries Removed:
Endometriosis
Ovarian Cyst
Ovarian Cancer
Tubal Ligation
Pancreatectomy
Prostate:
Prostate Removal
Prostate Biopsy
Prostate TURP/APR
Rectum - Low Anterior Resection
Skin:
Skin Biopsy
Basal Cell Cancer
Squamous Cell Cancer
Melanoma
Splenectomy
Orchiectomy
Uterus Hysterectomy:
Fibroids
Cervical Cancer
Uterine Cancer
Other: _____

Skin Disease History: (Please Circle All that Apply)

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

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Turn page to continue

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

Review of Systems: (Please Circle All that Apply)

Problems with Bleeding	Chest Pain	Seizures	Premedication Prior to Procedures
Problems with Healing	Cough	Shortness of Breath	Allergy to Adhesives
Problems with Scarring	Depression	Sore Throat	Allergy to Topical Antibiotic Ointments
Immunosuppression	Fever/Chills	Thyroid Problems	Blood Thinners
Changing Mole	Headaches	Unintentional Weight Loss	Pregnancy or Planning Pregnancy
Rash	Hay Fever	Wheezing	Allergy to Lidocaine
Abdominal Pain	Joint Aches	Pacemaker	Rapid Heart Beat w/ Epinephrine
Anxiety	Muscle Weakness	Defibrillator	Yeast Infections w/ Antibiotics
Bloody Urine	Neck Stiffness	Artificial Joints in last 2 years	GI Upset w/ Antibiotics
Blurry Vision	Night Sweats	Artificial Heart Valve	

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Pharmacy Name:_____ **Location**:_____

Current Medications: (Attach Additional Page if Necessary)

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

Family History: (Please check all that apply to your father, mother, brother, sister, son, and/or daughter.)

	Father	Mother	Brother	Sister	Son	Daughter
Basal Cell Skin Cancer						
Squamous Cell Skin Cancer						
Melanoma						
Other Cancer						
Arthritis						
Asthma						
Diabetes						
Eczema						
Heart Disease						
High Cholesterol						
Hypertension						
Lupus						

_____ _____

Patient Signature Date