GREATER NEBRASKA Dermatology

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Dermatology Adult Medical History Form

It is important to us that we provide you with the best care and service possible. Therefore, we ask that you complete this form so it can be reviewed by your health care provider. Please take the time to answer each question as accurately and completely as possible. The information you share may be helpful in determining your medical treatment. This form will be kept as part of your permanent medical record.

Name: Date:

Current Health Concerns:	Past Medical History
1. Describe concern or condition	Medical Conditions: Please circle any of the following that apply to you and then describe.
2. Location: Where did it first appear?	1. Previous skin cancer - basal cell carcinoma(s) squamous cell carcinoma(s)
3. Present for how long?	
4. Is there a known possible cause?	2. Previous melanoma
5. What have you used to treat to date?	3. Other Cancers
6. What if anything has helped?	4. Asthma
7. Please list your Current Medications:	5. Seasonal allergies
8. What are your Current Allergies?	6. Other Conditions

Previous Surgeries and Hospitalizations	Your Family History
Please provide information about surgeries you have had for any skin cancers or other conditions	What diseases or conditions run in your family?
1. Skin cancer surgeries Year (Please indicate if Mohs performed)	Please circle any of the following that apply, describe briefly and indicate the relative that had this condition.
	1. Melanoma
2. Previous surgeries/hospitalizations Year	2. Other skin cancers
	3. Seasonal allergies
	4. Asthma
	5. Other skin conditions

Personal Health Review		
Please check or add any health problem(s) that you have had in the past 6 months.		
General:	**Skin**	**Hematologic/Lymphatic**
☐ none	☐ normal	☐ normal
☐ unintentional weight loss	☐ keloids	☐ anemia (low blood count)
☐ fever	☐ poor healing	☐ bleeding problems
☐ difficulty swallowing	☐ other skin disorders	☐ enlarged lymph nodes
☐ special diet		☐ other:
☐ other:		
Cardiovascular	**Respiratory**	**Gastrointestinal**
☐ normal	☐ normal	☐ normal
☐ angina	☐ asthma	stomach ulcer
☐ artificial heart valve	☐ emphysema	☐ colitis (bowel inflammation)
☐ pacemaker	☐ other lung problem:	☐ other stomach problem:
☐ heart attack (when?)		
Neurological	**Psychiatric**	**Endocrine**
☐ normal	☐ normal	☐ normal
☐ stroke	☐ depression	☐ diabetes
☐ seizures	☐ anxiety attacks	☐ thyroid problems
☐ other:	☐ other:	☐ other:
Eyes/Ears/Nose/Throat	**Musculoskeletal**	**Infections:**
☐ normal	☐ normal	☐ none
☐ glaucoma	☐ arthritis	☐ hepatatis
☐ hearing aid	☐ artificial joint	☐ HIV/AIDS
☐ cosmetic surgery	☐ Is your physical activity limited? If yes, please describe.	☐ tuberculosis (T.B.)
☐ other:	☐ other:	☐ other:

Sun exposure

Have you had extensive sun exposure? Yes _____ No _____
How many blistering sunburns have you had? _____
Do you wear sunscreen? Yes _____ No _____
Daily use of sunscreen? Yes _____ No _____
What SPF? _____

Your Social History

1. Are you working now? Yes _____ No _____
2. What is (or was) your occupation?

3. Do you use tobacco? Yes _____ Amount _____No _____ Date Quit: _____
4. Do you use alcohol? Yes _____ No _____ If yes, type and amount used.

5. Do you or have you used street drugs? Yes _____ No _____ If yes, type and amount used.