Pine Belt Dermatology & Skin Cancer Center — Medical History Form

Date: _____ Patient Name: _____

What is/are the main reason(s) for your visit today? _____

Please list any medications you are currently taking:

_____

_____

Please list any allergies: _____

Current Weight: _____ Current Height: _____

Preferred Pharmacy Name and Phone Number _____

Please list surgical history (if applicable)

_____

Are you currently suffering from Hepatitis or HIV/AIDS? _____

Please circle if you currently have or have you ever had any of the following conditions?

Arthritis	Asthma	Atrial Fibrillation	Bone Marrow Transplant
Breast Cancer	Colon Cancer	COPD	Coronary Artery Disease
Diabetes	Eczema	Heartburn/GERD	Hearing Loss
High Blood Pressure	High Cholesterol	Hyperthyroidism	Hypothyroidism
Kidney Disease	Leukemia	Lung Cancer	Melanoma
Prostate (Enlarged)	Prostate Cancer	Precancerous Moles	Psoriasis
Radiation Therapy	Skin Cancer	Stroke	

Do you have a family history of Melanoma? If so, who? _____
Do you have a family history of Skin Cancer? If so, who? _____

Have you had the flu shot in the last 12 months? _____ Have you had the pneumonia Vaccine? _____
Do you Smoke? _____ If so, how many packs per day? _____
Do you drink alcoholic beverages? _____ If so, How many per day? _____
Do you use any illicit drugs? _____
Do you use IV Drugs? _____
Do you have any artificial/replaced joints? _____
Do you require antibiotics prior to any surgical procedures? _____
Do you have a prosthetic heart valve? _____
Do you have any implantable devices that have been surgically put in your body? _____

Do you have a living will? _____
Do you have a power of attorney for healthcare? _____
If so, please list name and relationship_____

Do we have your permission to reconcile your medications with your pharmacy? _____

Pine Belt Dermatology and Skin Cancer Center
Review of Systems

Patient Name: _____ Date: _____

Are you currently experiencing any of the following:	Yes	No
Rash		
Problems with healing		
Problems with scarring (keloids or thick scars)		
Immunosuppression		
Problems with bleeding		
Hay fever		
Chest pain		
Fever or chills		
Night sweats		
Unintentional weight loss		
Thyroid problems		
Sore throat		
Blurry vision		
Abdominal pain		
Bloody stool		
Bloody urine		
Joint aches		
Muscle weakness		
Neck Stiffness		
Headaches		
Seizures		
Cough		
Shortness of breath		
Wheezing		
Anxiety		
Depression		
Are, do you think you might be, or are you trying to get pregnant?		
If you are pregnant, do you breastfeed?		
Are you experiencing any pain at this time related to your visit with us today?		
IF YOU ARE EXPERIENCING PAIN, please circle your pain level below. Your level of pain on a scale of 0-10, with 0 being none and 10 being the highest level of pain you're experiencing. 0 1 2 3 4 5 6 7 8 9 10		

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