Pharmacy ☐
Photo ☐
Hx ☐
Meds ☐
Detailed HPI ☐
ROS Accurate ☐
Exam Location/EOE ☐
Records ☐
Impression Correlate w/HPI ☐
F/U ☐

# Medical History

MID-COLUMBIA
DERMATOLOGY

Time:

Provider:

Ins:

Room:

Appointment Date:_____ Patient Name:_____ Date of Birth:_____

## Reason(s) for today's visit:

### Problem 1

Description of problem:

Location of problem:

How long have you had the problem:

Previous treatment for the problem:

Were the previous treatments effective:

### Problem 2

Description of problem:

Location of problem:

How long have you had the problem:

Previous treatment for the problem:

Were the previous treatments effective:

## Preferred Pharmacy

Name: _____ City: _____

## Past Medical History

**Select any of the following medical conditions you have had:**

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Cancer: Breast
- ☐ Cancer: Colon
- ☐ Cancer: Lung
- ☐ Cancer: Prostate
- ☐ Cancer: Other_____
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis: A, B or C
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Lupus
- ☐ Lymphoma
- ☐ Multiple Sclerosis
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other_____

## Past Surgical History

**Have you had any surgeries on the following organs?**

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Live: Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy: Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ NONE
- ☐ Other_____

## Do you have any of the following:

☐ Pacemaker ☐ Artificial joints or heart valve

**Are you currently Pregnant or Breastfeeding:** ☐ **Yes** ☐ **No**

**Last Menstural Period: _____**

## Medications

List all current prescription or over the counter medication/supplements you are taking:

_____
_____
_____

## Allergies

List all allergies and reactions if known:

_____
_____
_____

## Current List of Doctors

_____
_____

## Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Atypical Nevus
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ 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

Last Full Body Skin Exam:_____

## Social History

**Smoking Status (please choose one):**

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking: _____

**Alcohol Intake (please choose one):**

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

**Occupation**:_____

## Family History

Has anyone is your family had the following problems:

- ☐ Basal Cell Skin Cancer — If yes, who_____
- ☐ Squamous Cell Skin Cancer — If yes, who_____
- ☐ Melanoma — If yes, who_____
- ☐ Acne — If yes, who_____
- ☐ Eczema — If yes, who_____
- ☐ Psoriasis — If yes, who_____
- ☐ Lupus — If yes, who_____

## Review of Systems

Are you having any of these skin symptoms:

- ☐ Excessive Bleeding
- ☐ Poor wound healing
- ☐ Sensitivity to sun
- ☐ Bruise easily
- ☐ Problems with hair
- ☐ Keloid scarring
- ☐ Problems with nails
- ☐ Skin sensitivity
- ☐ Allergy topical antibiotics
- ☐ Allergy to Band-Aids
- ☐ Sun exposure History: Mild Moderate Severe

Are you experiencing any of the following:

- ☐ Fever/chills
- ☐ Trouble sleeping because of skin problem
- ☐ Restricted activity because of skin problem

**Patient Signature:_____ Date:_____**