DERMATOLOGY CENTER OF ROCKLAND MEDICAL HISTORY FORM

Patient Name:_____**DOB:**_____**Date:**_____

Primary Care Physician:_____**Preferred Pharmacy:** _____

Reason For Visit – What is the reason for your visit today? How long has the condition been present?

_____

PAST MEDICAL HISTORY - Do you have, or have ever been diagnosed with any of the following conditions: (Check if YES)

☐ **NO PERTINENT MEDICAL HISTORY**	☐ Fainting	☐ Leukemia/Lymphoma
☐ Arthritis	☐ GERD/Gastritis/Reflux Disease	☐ Liver Disease
☐ Asthma	☐ Heart Disease	☐ Organ Transplant Recipient
☐ Autoimmune Disorder/Lupus	☐ Heart Murmur	☐ Pacemaker/AICD/Defibrillator
☐ Bleeding/Clotting Disorder	☐ Heart Valve Replacement/Repair	☐ Pre-procedure Antibiotics Necessary
☐ BPH (enlarged prostate)	☐ Hepatitis	☐ Prostate Cancer
☐ Breast Cancer	☐ High Blood Pressure	☐ Radiation Treatment
☐ Colon Cancer	☐ High Cholesterol	☐ Seizure Disorder
☐ Crohn's Disease/Ulcerative Colitis	☐ HIV/AIDS	☐ Stroke
☐ Depression/Mental Health	☐ Joint Replacement	☐ Thyroid Disorder/Cancer
☐ Diabetes	☐ Kidney Disease	☐ Tuberculosis

Other medical problems not listed above: _____

Patient Past Surgeries/Hospitalizations – List any major surgeries. Please include date of surgery.

_____

_____

SKIN HISTORY - Do you have, or have ever been diagnosed with any of the following conditions: (Check if YES)

☐ **NO SIGNIFICANT SKIN HISTORY**	☐ Cold Sores/Herpes	☐ Psoriasis
☐ Acne	☐ Dysplastic Nevi	☐ Rosacea
☐ Actinic Keratosis	☐ Eczema	☐ Squamous Cell Carcinoma
☐ Alopecia	☐ Keloids (overgrowth of scars)	☐ Urticaria/Hives
☐ Basal Cell Carcinoma	☐ Melanoma	☐ Warts

Note previous treatment(s) of any above:

_____

_____

History of other skin problems not listed above:

_____

CONTINUED ON BACK

FAMILY HISTORY – Please indicate afflicted family member

☐ **NO RELEVANT FAMILY HISTORY** ☐ Colon Cancer _____ ☐ Pancreatic Cancer _____

☐ Unknown - Adopted ☐ Dysplastic Nevi _____ ☐ Psoriasis _____

☐ Autoimmune Disorder _____ ☐ Eczema _____ ☐ Skin Cancer (BCC/SCC) _____

☐ Breast Cancer _____ ☐ Melanoma _____ ☐ Thyroid Cancer _____

Other skin problems not listed above: _____

UV Exposure – Check if YES

☐ Uses sunblock ≥ 30 SPF currently ☐ Current use of tanning booth

☐ History of blistering sunburn ☐ History of tanning booth use

Vaccine Received – Check if YES, please **include date**.

☐ COVID-19_____ ☐ Flu _____ ☐ Pneumonia _____

Tobacco Use – (if used one or more times within 24 months)

☐ No ☐ Yes

Alcohol Use

☐ No ☐ Yes

If yes, how many times in the past 12 months have you had (women 4, men 5) or more alcoholic beverages in a day?___

Height and Weight

Height (in) _____ Weight (lbs) _____

Patient Medications – Current medications and over-the-counter (OTC) supplements

_____

_____

_____

Patient Allergies – List any known allergies

_____

_____

For Women Only – Check if YES

☐ Pregnant ☐ Planning pregnancy ☐ Nursing

MEDICAL HISTORY VERIFICATION

The information provided above is accurate and complete to the best of my knowledge.

Patient Initials: _____ Date: _____

Parent/Guardian Initials: _____ Date: _____

FOR OFFICE USE ONLY

PATIENT ID NUMBER: _____