

INTERMOUNTAIN DERMATOLOGY MEDICAL HISTORY

Patient name: _____ Date: _____

Reason for visit: _____

Name of referring physician: _____

Name of primary care physician: _____

List other physicians involved in your care: _____

List all medications that have given you an allergic skin rash: _____

List all medications that have caused difficulty breathing: _____

List all medications that have caused nausea, diarrhea, abdominal pain: _____

List the names of all medications, including over-the-counter remedies and herbs, which you are currently taking:

Do you take coumadin / warfarin, aspirin, vit. E, or any other "blood thinners"? No Yes

Do you now have, or ever had diseases/disorders of the following:

Eyes/ears/ nose/throat	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Blood system/clotting	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Heart	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Blood sugar/diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Lungs	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Seizures	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Stomach/bowel	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Depression	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Kidneys	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Thyroid	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Joints/Muscles	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Blood pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Liver	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Lymph nodes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Immune system	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Reproductive organs	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Please explain any "yes" responses: _____

List any surgical procedures you have had: _____

Do you have a history of skin cancer? No Yes

If so, circle what type? Basal cell / Squamous cell / Melanoma / other

Is there a family history of melanoma? No Yes

Do you have pacemaker, defibrillator, or other implanted electrical device? No Yes

If so, what type and how long have you had it? _____

Have you been diagnosed with, or exposed to HIV/AIDS or Hepatitis No Yes

If so, please explain? _____

Do you form keloids (thick scars)? No Yes

Are you currently pregnant, trying to become pregnant, or breast feeding? No Yes
