Insurance:
Time:
Pharmacy ☐
Photo ☐

MID-COLUMBIA
DERMATOLOGY

Medical History

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:

Personal Medical History (Have you currently or previously had a problem with any of the following (if yes describe))

Melanoma	No	Yes_________________________	Kidney Problems	No	Yes__________________________
Squamous Cell	No	Yes_________________________	Diabetes	No	Yes__________________________
Basal Cell	No	Yes_________________________	High Blood Pressure	No	Yes__________________________
Cancer	No	Yes_________________________	High Cholesterol	No	Yes__________________________
Acne	No	Yes_________________________	Osteoporosis	No	Yes__________________________
Asthma	No	Yes_________________________	Peptic Ulcer Disease	No	Yes__________________________
Eczema	No	Yes_________________________	Hepatitis A, B or C	No	Yes__________________________
Heart Problems	No	Yes_________________________	Sun Allergy	No	Yes__________________________
Psoriasis	No	Yes_________________________	Allergies/Hayfever	No	Yes__________________________
Thyroid	No	Yes_________________________	Lupus	No	Yes__________________________

Please list any other medical history:

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

(turn over to finish)

Please list any past surgeries:

Family History (Has anyone is your family had the following problems)

Melanoma No Yes If yes, who____

Basal Cell No Yes If yes, who____

Squamous Cell No Yes If yes, who____

Acne No Yes If yes, who____

Eczema No Yes If yes, who____

Psoriasis No Yes If yes, who____

Has anyone is your family had skin problems similar to what you are being seen for today:

No Yes If yes, who____

Social History

Do you use tobacco/smoke No Yes If yes, type____

Do you drink alcohol No Yes If yes, amount____

Do you wear sunscreen No Yes If yes, SPF____

Occupation:____

Marital Status:____

Allergies

Please list any allergies to medications:

Medications

Please list any current prescription or over the counter medication you are taking:

Pharmacy preference:

List of current doctors:

Skin Review of System: (are you having any of these skin symptoms)

Excessive Bleeding	No	Yes	Poor wound healing	No	Yes
Sensitivity to sun	No	Yes	Bruise easily	No	Yes
Problems with hair	No	Yes	Keloid scarring	No	Yes
Problems with nails	No	Yes	Skin sensitivity	No	Yes
Allergy topical antibiotics	No	Yes	Allergy to Band-Aids	No	Yes

Sun exposure History: Mild Moderate Severe

Review of System: (Are you experiencing any of the following)

Fever/chills No Yes ____

Trouble sleeping because of skin problem No Yes____

Restricted activity because of skin problem No Yes ____

Do you have a pacemaker No Yes ____

Do you have artificial joints or heart valve No Yes ____

Are you pregnant or breastfeeding No Yes ____

Patient Signature:____ Date:_______________________