Medical History **Patient Name: ________________**

Please list the reasons for your visit today in each space provided.

Please circle one option for each problem.

1. Growth Rash Acne Other______________
Location of problem: ______________________
Duration: ________________________________
Symptom: Painful q Itchy q Other__________
Previous treatment tried: __________________
Effect of treatment: _______________________

2. Growth Rash Acne Other______________
Location of problem: ______________________
Duration: ________________________________
Symptom: Painful q Itchy q Other__________
Previous treatment tried: __________________
Effect of treatment: _______________________

3. Growth Rash Acne Other______________
Location of problem: ______________________
Duration: ________________________________
Symptom: Painful q Itchy q Other__________
Previous treatment tried: __________________
Effect of treatment: _______________________

4. Growth Rash Acne Other______________
Location of problem: ______________________
Duration: ________________________________
Symptom: Painful q Itchy q Other__________
Previous treatment tried: __________________
Effect of treatment: _______________________

Daily Prescription Medication: ____
Any **allergies** to Medication: ____

Please FILL in the bubbles for the following:

Fever	o Y	o N	**Seizures**	o Y	o N	**Thyroid Disease**	o Y	o N
Chills	o Y	o N	**Kidney Disorder**	o Y	o N	**Diabetes**	o Y	o N
Weight Loss	o Y	o N	**Bleeding Disorder**	o Y	o N	**Dysplastic Nevus**	o Y	o N
Diarrhea	o Y	o N	**Heart Abnormality**	o Y	o N	**Asthma**	o Y	o N
Stomach Ulcer	o Y	o N	**Depression/Psychosis**	o Y	o N	**Eczema**	o Y	o N
Migraine	o Y	o N	**High Blood Pressure**	o Y	o N	**Hay Fever/Allergies**	o Y	o N

List any other significant medical issues / surgical procedures not listed above? __________________________
OCCUPATION: ____

Melanoma o Y o N When: ________ **Other type of Cancer** o Y o N When: __________
Skin Cancer (BCC/SCC) o Y o N When: ________ **If Yes, Radiation or Chemotherapy?** o Y o N

Tanning Parlor use:	o Active	o Past	o Never
Smoking:	o Active	o Past	o Never
Alcohol Consumption:	o Active	o Past	o Never

For women only: Are you pregnant or trying to get pregnant? Yes q No q Due Date: __/___/___

Family History: Asthma, Hay Fever, Eczema q Who: ______ Abnormal moles q Who: ________
Melanoma q Who:__________ **Other Skin Cancer** (BCC or SCC) q Who: ______
Other type of Cancer o Y o N Who: __________