MICHELE M. THOMPSON, M.D.
DERMATOLOGY

HEALTH HISTORY

Patient's Name:_____ Date:_____

What are your skin concerns today?_____

Past Medical History *(check all that apply)*:

□ Anxiety
□ Arthritis
□ Asthma
□ Atrial fibrillation
□ Bleeding tendency
□ Blood clot
□ Cancer (other than skin):
*(type)*_____
*(type)*_____
□ Coronary artery disease
□ Depression
□ Diabetes
□ Eye or vision problems
□ Heart disease
□ HIV / AIDS
□ Hepatitis B
□ Hepatitis C
□ High blood pressure
□ High cholesterol
□ Keloids or abnormal healing
□ Leg swelling or varicose veins
□ Liver disease
□ Lymphoma
□ Radiation treatment
□ Stroke
□ Thyroid disorder
□ Other:_____

Past Surgeries *(check all that apply)*:

□ Appendix removed
□ Bladder removed
□ Mastectomy (R, L, Bilateral)
□ Lumpectomy (R, L, Bilateral)
□ Breast biopsy (R, L, Bilateral)
□ Breast reduction
□ Breast implants
□ Colectomy: colon cancer resection
□ Colectomy: Diverticulitis
□ Colectomy: IBD
□ Gallbladder Removed
□ Coronary artery bypass
□ Mechanical valve replacement
□ Biological valve replacement
□ Heart transplant
□ Joint replacement, knee (R, L, Bilateral)
□ Joint replacement hip (R, L, Bilateral)
□ Joint replacement within last 2 years
□ Knee biopsy
□ Kidney removed
□ Kidney stone removal
□ Kidney transplant
□ Ovaries removed: endometriosis
□ Ovaries removed: cyst
□ Ovaries removed: ovarian cancer
□ Prostate removed: prostate cancer
□ Prostate biopsy
□ TURP (prostate removal)
□ Spleen removed
□ Testicles removed
□ Hysterectomy: Fibroids
□ Hysterectomy: uterine cancer

Skin Disease History *(check all that apply)*:

□ Acne
□ Actinic Keratoses
□ Asthma
□ Basal Cell Skin Cancer
□ Blistering Sunburn
□ Dry Skin
□ Eczema
□ Flaking or Itchy Scalp
□ Hay Fever / Allergies
□ Melanoma
□ Poison Oak
□ Precancerous Moles
□ Psoriasis
□ Squamous Cell Skin Cancer
□ Other:_____
_____
_____
_____
_____
_____
_____

Do you wear sunscreen? □ No □ Yes, SPF:_____

Do you use tanning beds? □ Never □ Occasionally use(d) tanning bed □ Regularly use tanning beds

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Do you have a family history of Melanoma? □ No □ Yes, relative:_____
Do you have a family history of other skin cancer? □ No □ Yes, relative:_____

Have you had your **flu vaccine**? □ No □ Yes Date:_____
If you are 65 or older have you **EVER** had a pneumonia vaccine? □ No □ Yes

Current Medications: If none, please write "none". *Include strength, dose, form and frequency.* If more space is needed, ask for an additional page.

_____ _____
_____ _____
_____ _____

Allergies to medications: If no known drug allergies, write "none". If more space is needed, ask for an additional sheet.

_____ _____
_____ _____

Preferred Pharmacy:_____
Name Location Phone

Do you smoke: □ Currently smokes □ Formerly smoked □ Never smoked
Alcohol use: □ None □ Less than 1 drink per day □ 1 to 2 drinks per day □ 3 or more drinks per day
Where did you grow up?_____
Your occupation and place of work:_____

SYMPTOMS (please check all that apply to you):

□ Fever or chills
□ Malaise
□ Unintentional weight loss
□ Problems with bleeding
□ Problems with healing
□ Problems with scarring
□ Hay fever
□ Cough
□ Chest plain
□ Night sweats
□ Thyroid problems
□ Sore throat
□ Shortness of breath
□ Bloody stool
□ Bloody urine
□ Joint aches
□ Muscle weakness
□ Headaches
□ Seizures
□ Irregular menses

Do you have any of the following:

□ Pregnant, trying to conceive, breastfeeding
□ Allergy to adhesive
□ Allergy to lidocaine
□ Allergy to topical antibiotics
□ Artificial heart valve
□ Blood thinners
□ Rapid heartbeat with epinephrine
□ Immunosuppression
□ MRSA
□ Require antibiotics prior to surgery
□ Implantable devices (Pacemaker, Defibrillator, Neurostimulator)

Cosmetic Interest: (check if you would like information about any)

□ Age spot treatment
□ Botox
□ Latisse
□ Retin A
□ Sunscreen advice
□ Skin care advice
□ Wrinkle correction

Signature:_____ Print Name:_____ Date:_____