CLAYTON DERMATOLOGY GROUP

Medical History Form

Name: ____ DOB: ________________________

Medical History: (Circle all that apply)

Anxiety	Depression	Hyper/Hypothyroidism
Arthritis	Diabetes	Leukemia
Asthma	Enlarged Prostate	Lung Cancer
Atrial Fibrillation	GERD	Lymphoma
Bone Marrow Transplant	Hearing Loss	Prostate Cancer
Breast Cancer	Hepatitis B or C	Radiation Treatment
Colon Cancer	Hypertension	Renal Disease (End Stage)
COPD	High Cholesterol	Seizures
Coronary Artery Disease	HIV/AIDS	Stroke

Other:____

Surgical History:

Procedure: ____ Date: ___________________

Procedure: ____ Date: ___________________

Skin History: (Circle all that apply)

Acne	Eczema	Precancerous Moles
Actinic Keratosis	Flaking or Itchy Scalp	Psoriasis
Basal Cell Carcinoma	Hay Fever/Allergies	Squamous Cell Carcinoma
Blistering Sunburn	Melanoma	Other: ________________
Dry Skin	Poison Ivy	

Use of: **Tanning Beds/Salon:** ☐ Yes ☐ No **Sunscreen:** ☐ Yes ☐ No

Family History:

Is there a family history of Melanoma? ☐ Yes ☐ No Relative: ____________________________

Allergies:

None ☐ List all medication allergies: ____

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Occupation: ____

Review of Systems: (Circle all that apply)

Artificial Heart Valve	Blood Thinners
Artificial Joints within the Past 2 Years	Problems with Healing
Allergy to Adhesive	Problems with Scarring (Hypertrophic or Keloid)
Allergy to Topical Antibiotic Ointment	Rash
Antibiotics Prior to Procedures	Transplant History

Alerts: (Circle all that apply)

Lidocaine Allergy	Pace Maker / Defibrillator	Latex Allergy
Rapid Heartbeat with Epinephrine	Pregnancy / Nursing	

Nicotine Use: ☐ Former Smoker ☐ Current Smoker ☐ Never Smoked

Alcohol Use: ☐ Less than 1/Day ☐ 1-2 Drinks/Day ☐ 3 or More/Day

This season, have you received a flu vaccine? ☐ Yes ☐ No

If over 65, have you received pneumonia vaccine? ☐ Yes ☐ No

Name of your primary care physician?____

☐ Never