DERMATOLOGY ASSOCIATES of York, Inc.

PATIENT MEDICAL HISTORY FORM

Name: _____ Date: _____

Date of Birth: _____ Name of Family Physician: _____

If this is your first visit to our office, how did you hear about our practice? *(please circle):*

Family Physician Friend/Family Member Insurance Company Website Phone Book Other: _____

Understanding your health history is very important to us in treating your health problems. Please take the time to fully and completely fill out the information below. If you have any questions or any of the questions need clarification, please ask us.

1. Race *(please circle):* White Black/African American American Indian/Alaska Native Asian
   Native Hawaiian/Other Pacific Islander Other _____
2. Ethnicity *(please circle):* Spanish/Hispanic Origin Not of Spanish/Hispanic Origin
3. Preferred Language *(please circle):* English Other _____
4. Height _____ ft. _____ in. Weight _____ lbs.
5. Please list medications for skin problems: _____
   _____
6. Please list current medications, vitamins, supplements, and any nonprescription items:
   _____
   _____
   _____
   _____
7. Are you currently taking Blood thinners? *(please circle):*
   Coumadin Aspirin Plavix Warfarin Xarelto Pradaxa Eliquis
8. Do you have a PACEMAKER and/or DEFIBRILLATOR? *(please circle):* _____ Yes No
9. Please list allergies to medication: _____
10. Please list allergies to foods, plants, or other substances: _____
    _____
11. Have you had any joint replacements? *(please circle):* _____ Yes No
    If yes, which joint(s) _____
12. Have you had skin cancer? *(please circle):* _____ Yes No
    If so, what type? (please circle) _____
    Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma Other: _____
    If you had melanoma in the past, where on your body was the cancer and when were you diagnosed?
    _____
13. Have you had any skin problems in the past? *(please circle):* _____ Yes No
    Eczema Psoriasis Other: _____
14. Have any of your family members had skin cancer? *(please circle):* _____ Yes No
    If yes, which family member had skin cancer and what type? (please circle)
    Mother Father Brother Sister Grandmother Grandfather Other: _____
    Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma Other: _____
15. Have any of your family members had skin problems? *(please circle):* _____ Yes No
    Eczema Psoriasis Other: _____
    If so, which family member had skin problem? (please circle)
    Mother Father Brother Sister Grandmother Grandfather Other: _____

continued on other side →

16. Have you ever had any internal cancer? *(please circle):* Yes No

If yes, what type of cancer did you have? _____

17. Please circle if you have OR had any of the following:

ENDOCRINE PROBLEMS
DIABETES
HYPOTHYROIDISM
HYPERTHYROIDISM

KIDNEY PROBLEMS
KIDNEY DISEASE
KIDNEY FAILURE
URINARY TRACT
PROSTATE DISEASE

RESPIRATORY PROBLEMS
TUBERCULOSIS
COPD
ASTHMA

INTESTINAL DISEASE
LIVER DISEASE
HEPATITIS type _____
COLITIS

EAR, NOSE, THROAT OR
MOUTH PROBLEMS
SINUS TROUBLE
HAY FEVER
ALLERGIES

PSYCHIATRIC ILLNESS
DEPRESSION
ANXIETY
BIPOLAR DISORDER

RHEUMATOLOGIC DISEASE
LUPUS
ARTHRITIS
CONNECTIVE TISSUE DISEASE

NEUROLOGICAL DISEASE
EPILEPSY
SEIZURES
MYASTHENIA GRAVIS
PARKINSON'S

EYE PROBLEMS
CATARACTS
GLAUCOMA
MACULAR DEGENERATION

ORGAN TRANSPLANT
KIDNEY
HEART
LUNG
LIVER
OTHER _____

CARDIOVASCULAR PROBLEMS
HEART ATTACK
ANGINA
HEART MURMUR
ARTERIOSCLEROSIS
RHEUMATIC HEART DISEASE
STROKE
HIGH BLOOD PRESSURE
STENTS
DAMAGED HEART VALVE
BLOOD CLOTS
ARTIFICIAL HEART VALVE
VASCULAR DISEASE
OPEN HEART SURGERY

AT RISK FOR HIV or HIV+

18. Please explain any conditions circled above and list any additional medical problems or history you may have:

_____

19. Have you had any recent surgeries or hospitalizations? *(please circle):* Yes No

If yes, please explain: _____

20. Marital Status *(please circle):* Single Married Divorced Widowed Legally Separated Domestic Partner
21. Please list any pets you have at home: _____
22. What is your occupation? _____
23. Do you smoke? *(please circle):* Yes No

If yes, how many cigarettes do you smoke per day? _____

24. Do you drink alcohol? *(please circle):* Yes No

If male, do you ever drink more than 5 alcoholic beverages at a time? (please circle): Yes No

If female, do you ever drink more than 4 alcoholic beverages at a time? (please circle): Yes No

25. Are you currently using illegal drugs? *(please circle):* Yes No
26. Have you ever been to a tanning bed? *(please circle):* Yes No

If yes, are you still using a tanning bed? Yes No

27. Do you regularly use sunscreen? *(please circle):* Yes No

If yes, what SPF? _____

28. Are you pregnant, nursing, or planning to get pregnant in the next 6 months? *(please circle):* Yes No
29. Please list any type of birth control you are using: _____

SIGNED BY ALL PATIENTS

The above information is true and correct to the best of my belief.

Patient/Authorized Representative Signature:

_____ Date: _____

OFFICE USE ONLY

Reviewed by Doctor/Physician Assistant

Signature:

_____ Date: _____