DERMATOLOGY ASSOCIATES of York, Inc.

PATIENT MEDICAL HISTORY FORM

Name: _____ Date: _____

Date of Birth: _____ Name of Family Physician: _____

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. Sex at Birth *(please circle)*: Male Female
6. Gender Identity *(please circle)*: Male Female Transgender Male Transgender Female
   Other *(please specify)*: _____
7. Please list current medications, vitamins, supplements, and any nonprescription items, including dosage and frequency:

   _____

   _____

   _____

   _____
8. Are you currently taking blood thinners? *(please circle):*
   Coumadin Aspirin Plavix Warfarin Xarelto Pradaxa Eliquis
9. Do you have a PACEMAKER and/or DEFIBRILLATOR? *(please circle):* Yes No
10. Please list allergies to medications, 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 problems? (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:

DIABETES	SINUS TROUBLE	EPILEPSY	HEART ATTACK
HYPOTHYROIDISM	HAY FEVER	SEIZURES	ANGINA
HYPERTHYROIDISM	ALLERGIES	MYASTHENIA GRAVIS	HEART MURMUR
		PARKINSON'S	ARTERIOSCLEROSIS
KIDNEY DISEASE	DEPRESSION		RHEUMATIC HEART DISEASE
KIDNEY FAILURE	ANXIETY	CATARACTS	STROKE
URINARY TRACT	BIPOLAR DISORDER	GLAUCOMA	HIGH BLOOD PRESSURE
PROSTATE DISEASE		MACULAR DEGENERATION	STENTS
	LUPUS		DAMAGED HEART VALVE
TUBERCULOSIS	ARTHRITIS	ORGAN TRANSPLANT	BLOOD CLOTS
COPD	CONNECTIVE TISSUE DISEASE	KIDNEY	ARTIFICIAL HEART VALVE
ASTHMA		HEART	VASCULAR DISEASE
		LUNG	OPEN HEART SURGERY
LIVER DISEASE		LIVER	
HEPATITIS type _____		OTHER _____	AT RISK FOR HIV or HIV+
COLITIS			

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 use any form of tobacco? *(please circle):* Yes No

☐ Cigarettes *(how many per day)*_____ ☐ Cigars ☐ Pipe ☐ Smokeless ☐ Electronic cigarettes

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: _____