COASTALDERMATOLOGY Medical History

Patient Name:_____

Past Medical History: (please circle all that apply) NONE

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bone Marrow
- ☐ Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood pressure
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Thyroid Problems
- ☐ (Hypo or Hyper)
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke

Other _____

Past Surgical History: (please circle all that apply) ☐ NONE

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Lumpectomy (Right, Left, Bilateral)
- ☐ Breast Biopsy (Right, Left, 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 (Right, Left, Bilateral)
- ☐ Joint Replacement, Hip (Right, Left, Bilateral)
- ☐ Joint Replacement within last 2 years
- ☐ Kidney Biopsy (Nephrectomy)
- ☐ Kidney Removed (Right, Left)
- ☐ 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 (Right, Left, Bilateral)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer

Other _____

ALERTS: (please circle all that apply)

- ☐ Allergy to Adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotics
- ☐ Artificial heart valve
- ☐ Artificial joint replacement in last 2 years
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Pacemaker
- ☐ Require antibiotics prior to a surgical or dental procedure
- ☐ Rapid heart beat with epinephrine
- ☐ Pregnant or currently trying to get pregnant

COASTALDERMATOLOGY Medical History

Skin Disease History: (please circle all that apply) ☐ NONE

☐ Acne	☐ Dry Skin	☐ Poison Ivy
☐ Actinic Keratoses	☐ Eczema	☐ Precancerous Moles
☐ Asthma	☐ Flaking or Itchy Scalp	☐ Psoriasis
☐ Basal Cell Skin Cancer	☐ Hay Fever/Allergies	☐ Squamous Cell Skin
☐ Blistering Sunburns	☐ Melanoma	☐ Cancer

Other _____

Do you have a family history of Melanoma? ◉ Yes ○ No
If yes, which relative(s)?

Do you wear Sunscreen? ○ Yes ◉ No
If yes, what SPF?
Do you tan in a tanning salon? ○ Yes ◉ No

Medications: (Please enter all current medications)

Allergies: (Please enter all allergies)

Social History: (Please circle all that apply)

Cigarette Smoking:

- ○ Currently Smokes
- ○ Has smoked in the past
- ○ Never smoked
- ○ Former Smoker

Alcohol Use:

- ○ EtOH- None
- ○ EtOH- less than 1 drink per day
- ○ EtOH -1-2 drinks per day
- ○ EtOH -3 or more drinks per day

Preferred Language:

- ○ English
- ○ Spanish
- ○ Other:_____

Race:

- ○ White
- ○ Black/African America
- ○ Asian
- ○ American Indian or
- ○ Native Alaskan
- ◉ Other:_____

Ethnic Group:

- ○ Non-Hispanic/Latino
- ○ Hispanic/Latino

Preferred Pharmacy: _____Phone #: _____

Address:_____City, State & Zip:_____