MEDICAL HISTORY FORM

Name	Age	Date of Birth	Date

What is the reason for your visit today?

ALLERGIES

PHARMACY: **Address/phone number:**

PRIMARY CARE DR

MEDICAL HISTORY **Current/prior medical problems:**

1.
2.
3.
4.
5.
6.
7.
8.

DERMATOLOGIC HISTORY

- ☐ Melanoma
- ☐ Squamous Cell Carcinoma
- ☐ Basal Cell Carcinoma
- ☐ Skin Cancer, Uncertain Type
- ☐ Dysplastic (Atypical) Moles
- ☐ Actinic Keratoses (Pre-cancer)
- ☐ Eczema
- ☐ Psoriasis

SURGICAL HISTORY **Date:**

1.
2.
3.
4.
5.
6.

SOCIAL HISTORY **Please circle/fill in:**

Alcohol: None
Yes Amount

Tobacco: None
Yes Amount

Drug Use: None
Yes Explain

MEDICATIONS **Please list your current medications:**

1.
2.
3.
4.
5.
6.
7.
8.

FAMILY HISTORY **Please list family members:**

- ☐ Melanoma
- ☐ Squamous Cell Carcinoma
- ☐ Basal Cell Carcinoma
- ☐ Skin Cancer, Uncertain Type
- ☐ Dysplastic (Atypical) Moles
- ☐ Actinic Keratoses (Pre-cancer)
- ☐ Eczema/Psoriasis
- ☐ Other

SUN EXPOSURE HISTORY **Please circle one:**

Lifetime Sun Exposure:	Mild Moderate Heavy
Hist. of Blistering Sunburn:	Yes No
Sunscreen Use:	Always Occas. Never

Prescription History Consent

☐ YES ☐ NO

MORRIS DERMATOLOGY

CARY ANN JENKINS, MD