REISENAUER
DERMATOLOGY

# MEDICAL HISTORY FORM

Name: ______________________ Date of Visit: __________

Age: ______ Birth date: __________ Referring Physician: __________

## REASON(S) FOR TODAY'S VISIT (MAY CHECK MORE THAN ONE):

- ☐ Full Skin Check
- ☐ Lesion(s) of concern, Location: ______________________ (Location on body)
- ☐ Acne
- ☐ Rash, Location: ______________________ (Location on body)
- ☐ Other: ______________________

## CHECK ANY MEDICAL CONDITIONS THAT YOU CURRENTLY HAVE:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Bone Marrow Transplantation
- ☐ BPH (enlarged prostate)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD (chronic obstructive pulmonary disease)
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (gastroesophageal reflux disease)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension (high blood pressure)
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia (high cholesterol)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other ______________________

## PLEASE LIST ANY MAJOR SURGERIES YOU HAVE HAD

Reisenauer Dermatology

## CHECK ANY CONDITIONS YOU HAVE HAD:

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Allergic Contact Dermatitis
- ☐ Atypical Moles
- ☐ Basal Cell Skin Cancer — Location on body
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay fever/Allergies
- ☐ Melanoma — Location on body
- ☐ Poison ivy
- ☐ Precancerous Moles — Location on body
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer — Location on body
- ☐ Warts
- ☐ Other

## DO YOU WEAR SUNSCREEN WHENEVER YOU GO OUTSIDE?

☐ YES What SPF? How often do you re-apply?

☐ NO

## DO YOU WEAR A HAT WHENEVER YOU GO OUTSIDE?

☐ YES ☐ NO

**FAMILY HISTORY** (please list **immediate family members** only):

Melanoma:

Other cancer (speci fy type):

Eczema/Asthma/Hay fever:

Psoriasis:

## CURRENT MEDICATIONS

Include strengths if possible (including prescriptions, over-the-counter meds, vitamins, and herbals)

## ARE YOU ALLERGIC TO ANY MEDICATION?

☐ YES If yes, what medicine and what is your reaction?

☐ NO

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**ARE YOU ALLERGIC TO LATEX?** ☐ YES ☐ NO

**SOCIAL HISTORY:**

☐ Never a smoker

☐ Current smoker Packs/Day ______ Number of years ______

☐ Former smoker Year you started ______ Year you stopped ______

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? ______

**REVIEW OF SYSTEMS (PLEASE CHECK ALL THAT APPLY TO YOU CURRENTLY):**

☐ problems with bleeding
☐ problems with healing
☐ problems with scarring
☐ rash
☐ immunosuppression
☐ hay fever
☐ chest pain
☐ fever
☐ chills
☐ night sweats
☐ unintentional weight loss
☐ thyroid problems
☐ sore throat
☐ blurry vision
☐ abdominal pain
☐ bloody stool
☐ bloody urine
☐ joint aches
☐ neck stiffness
☐ muscle weakness
☐ headaches
☐ seizures
☐ cough
☐ shortness of breath
☐ wheezing
☐ anxiety
☐ depression
☐ other ______
☐ none apply to me

**ALERTS (PLEASE CHECK ANY THAT APPLY TO YOU):**

☐ allergy to adhesive
☐ allergy to lidocaine
☐ allergy to topical antibiotic ointment Please list ______
☐ artificial heart valve
☐ artificial joints within past two years
☐ blood thinners
☐ defibrillator
☐ h/o MRSA (Staph infection)
☐ pacemaker
☐ rapid heartbeat with epinephrine
☐ pregnancy or planning a pregnancy
☐ none apply to me

**Mahalo for taking the time to complete our form.**

Please download or save this form with your changes and either email it to info@RDMaui.com or print and mail it to Reisenauer Dermatology at the address below.