Medical History

Name: _____ Date of Birth: _____ Gender: Male / Female

MEDICAL HISTORY (CHECK ALL THAT APPLY):

- ☐ Heart Disease
- ☐ Heart murmur
- ☐ Defibrillator
- ☐ Artificial heart valve
- ☐ Mitral valve prolapses
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Seasonal Allergies
- ☐ Sexually Transmitted Diseases
- ☐ HIV/AIDS
- ☐ Diabetes
- ☐ Pregnant or Nursing
- ☐ Stomach/duodenal ulcer
- ☐ Use blood thinners
- ☐ Sickle Cell Anemia
- ☐ Pneumonia
- ☐ Pacemaker
- ☐ Hemophilia
- ☐ Arthritis
- ☐ Artificial Joint
- ☐ Hepatitis
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Thyroid disease
- ☐ Lupus
- ☐ Fever blisters
- ☐ Depression
- ☐ Glaucoma
- ☐ Anemia
- ☐ COPD
- ☐ Cancer

Type_____

When_____

SKIN CANCER HISTORY:

Have you ever had skin cancer? **YES / NO**

If YES, what type?

- ❑ Squamous Cell Carcinoma
- ❑ Basal Cell Carcinoma
- ❑ Melanoma
- ❑ Other: _____

SKIN DISEASE HISTORY:

- ❑ Psoriasis
- ❑ Eczema
- ❑ Acne
- ❑ Actinic Keratosis/Pre-cancerous lesions
- ❑ Keloids or Scars
- ❑ Other: _____

FAMILY HISTORY:

Family history of skin cancer? **YES / NO**

Who?_____

What type?

- ❑ Squamous Cell Carcinoma
- ❑ Basal Cell Carcinoma
- ❑ Melanoma
- ❑ Other: _____

SOCIAL HISTORY:

Do you smoke? **YES / NO** If YES, packs per day_____

Do you drink alcohol? **YES / NO** **I**f YES, how often_____

SURGICAL HISTORY:

_____

_____

ALLERGIES:

_____

_____

MEDICATIONS: (please list all current prescription and non-prescription items, supplements etc. If none, please note)

_____

_____

_____

_____

I have completed this form to the best of my ability. If I have a change in my health, I will notify you at my next Appointment.

Patient Signature_____ Date: _____

Cinco Ranch Dermatology
23050 Westheimer Pkwy, Katy, TX 77494
281-394-9500