

**Dermatology Associates of Lancaster, Ltd.**  
**Patient History Form**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name of Family Physician/Group:** \_\_\_\_\_

**Medication Allergies:** None Yes **List:** \_\_\_\_\_

**Medications you take:** \_\_\_\_\_

**Do you have the following:** Pacemaker Defibrillator Deep Brain Stimulator Cochlear Implant

<b>MEDICAL HISTORY:</b>	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts (Glaucoma)	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Urinary/Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Thrombophlebitis (blood clots)	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Emotional/Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Infections (skin/other)	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Keloids	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	<i>Other current medical problems:</i> _____		
Colitis	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>			

- Prior Surgeries (in last 5 years): \_\_\_\_\_
- Do you take: Aspirin Ibuprofen (Advil, Motrin) Naproxen (Aleve) Dipyridamole Coumadin (Warfarin) Plavix (Clopidogrel) Pradaxa (Dabigatran) Xarelto (Rivaroxaban) Vitamin E or Fish Oil
- Do you take prophylactic antibiotics for dental surgery? Yes No
- Prior skin cancer? Melanoma Basal cell carcinoma Squamous cell carcinoma Unsure of type
- Other Cancer/Date: \_\_\_\_\_
- **FAMILY HISTORY:** Melanoma (relationship) \_\_\_\_\_ Other Skin Cancer \_\_\_\_\_  
Other skin problems (eczema, psoriasis, lupus, etc.): \_\_\_\_\_
- **SOCIAL HISTORY:** Do you smoke? Yes No Do you drink alcohol? Yes No # drinks/week \_\_\_\_\_  
Current occupation? \_\_\_\_\_

<b>CURRENT SYMPTOMS:</b> Are you experiencing any of the following?					
	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
Fever/Chills	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising or bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	Changes in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Vision changes/blurriness of vision	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Photosensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Joint/muscle aches	<input type="checkbox"/>	<input type="checkbox"/>
Mouth Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Bone pain	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath/chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Dryness of skin	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling in fingers	<input type="checkbox"/>	<input type="checkbox"/>
Swollen lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	Depression/suicidal ideation	<input type="checkbox"/>	<input type="checkbox"/>
Lumps/bumps or growths (including breast or scrotum)	<input type="checkbox"/>	<input type="checkbox"/>			

**OFFICE USE ONLY:** Reviewed by \_\_\_\_\_ Date \_\_\_\_\_  
Reviewed by \_\_\_\_\_ Date \_\_\_\_\_