University Dermatology - Dr. Ronald Hamrick

Dermatology Medical History Form

Date: \_\_\_\_\_\_\_\_\_\_\_ Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_ MRN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for today’s visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How tall are you? \_\_\_\_\_ ft. \_\_\_\_\_ in. How much do you weigh? \_\_\_\_\_\_\_\_\_\_\_ lbs.

Pharmacy (name/location/phone): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medications? Yes No if yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you currently have or ever have had any of the following conditions**:

Chronic Bronchitis Yes No Diabetes: type 1 or type 2 (circle) Yes No

Emphysema Yes No Thyroid: hypo or hyper (circle) Yes No

Asthma Yes No Kidney Yes No

High Blood Pressure Yes No Bladder Yes No

High Cholesterol Yes No Bowel Yes No

Heart Attack Yes No Hepatitis Yes No

Heart Murmur Yes No Glaucoma Yes No

Irregular Heartbeat Yes No Arthritis/Joint Deformity Yes No

Pacemaker Yes No Convulsions, Epilepsy or Seizure Yes No

Phlebitis Yes No Fainting Yes No

Exposure to HIV (AIDS) Yes No Herpes (fever blisters) Yes No

Depression/Anxiety Yes No End Stage Renal Yes No

Mood or Behavioral Disorder Yes No COPD Yes No

A-Fib Yes No Cancer: type \_\_\_\_\_\_\_\_\_\_\_ Yes No

Stroke Yes No Immunosuppression Yes No

Cough Yes No Diarrhea Yes No

Fatigue Yes No Vomiting Yes No

Headaches Yes No Abdominal Pain Yes No

Organ Transplant Yes No

Have you ever had anesthesia? Yes No if yes, any reactions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? Yes No if yes, how much? \_\_\_\_\_\_\_\_ if no, have you ever smoked? Yes No

Do you bleed easily? Yes No

Are you pregnant? Yes No Planning Pregnancy? Yes No Breastfeeding? Yes No

 **Please list the last date of the following**:

flu vaccine: \_\_\_\_\_\_\_\_\_\_\_ PAP Smear: \_\_\_\_\_\_\_\_\_\_\_

pneumonia vaccine: \_\_\_\_\_\_\_\_\_\_\_\_ Mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_

COVID vaccine: \_\_\_\_\_\_\_\_\_\_\_\_ Colonoscopy: \_\_\_\_\_\_\_\_\_\_\_

How often do you use the tanning bed? Never Occasionally Frequently Used in Past

How often do you use sunscreen? Never Occasionally Frequently

Have you ever had skin cancer? Yes No if yes, what type/when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has an immediate family member had melanoma? Yes No if yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of any specific skin disease? Yes No if yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of MRSA? Yes No

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all past surgeries with approximate dates:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin Disease History: (please circle all that apply)**

Acne Blistering sunburn Dry Skin Eczema Excessive sun exposure

Flaking scalp Lupus Psoriasis Actinic Keratosis Atypical Moles Melanoma

Basal Cell Carcinoma Squamous Cell Cancer Psoriasis Poison Ivy Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History: (please circle all that apply)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | mother | father | sister | brother | daughter | son | other |
| Acne |  |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |
| Atypical moles |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |
| Eczema |  |  |  |  |  |  |  |
| Allergies |  |  |  |  |  |  |  |
| Lupus |  |  |  |  |  |  |  |
| Psoriasis |  |  |  |  |  |  |  |
| Non-Melanoma Skin Cancers |  |  |  |  |  |  |  |