Date: _____

COLUMBIA SKIN CLINIC

Medical History

PATIENT: _____
Last Name *First Name* *Middle Initial* *Preferred Name*

Date of Birth: __/___/___ Reason for your visit today: _____

Primary Care Physician: _____ Referring Physician: _____

PREFERRED PHARMACY: _____ Address: _____

Patient's Past Medical History (please circle all that apply)

Anxiety	Diabetes	Problems Scarring
Arthritis	End Stage Renal Disease	Radiation Treatment
Artificial heart valve	GERD	Seizures
Artificial joint(s):_____	Hepatitis	Stroke
Asthma	High Blood Pressure	Psychiatric Care
Atrial Fibrillation	HIV/AIDS	Pregnant/Breast Feeding
Bleeding Disorders	High Cholesterol	Transplant: _____
Cancer: _____	Hyperthyroidism	Date: _____
COPD	Hypothyroidism	Trying to become pregnant
Coronary Artery Disease	Pace Maker	Other: _____
Depression	Problems Healing	

Surgical History: _____

Patient's Skin Disease History (please circle all that apply)

Acne	Eczema	Precancerous Moles
Actinic Keratosis	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	Other: _____
Dry Skin	Poison Ivy	

Patient's Family History

Do you have a family history of melanoma? _____ If yes, which relative(s)? _____

Medications (please list all current medications and dosages)

_____

_____

_____

_____

Allergies (please list all allergies & describe reaction, i.e. hives, anaphylaxis, etc.)

_____

_____

Social History

Tobacco use: □ non-smoker □ current smoker □ former smoker

Drug use: □ yes □ no

Alcohol use: □ none □ less than 1 drink/day □ 1-2 drinks/day □ 3+ drinks/day

Occupation and Place of Employment: _____