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: _____ Pharmacy Address: _____

If patient is under the age of 20, please list patient's estimated height and weight: _____

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

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

Surgical History: _____

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

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

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: □ never smoked □ currently smoke □ formerly smoked

Drug use: □ yes □ no

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

Occupation and Place of Employment: _____