Date: _____

COLUMBIA SKIN CLINIC

Medical History

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

Date of Birth: __/___/___ Sex Assigned at Birth: _____ Preferred Gender Identity: _____

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

Surgical History: _____

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

Acne	Eczema	Psoriasis
Actinic Keratosis	Itchy Scalp	Squamous Cell Skin Cancer
Basal Cell Skin Cancer	Melanoma	Other: _____

Do you have a living will? Y/N **Do you have a Health Care Proxy?** Y/N
Do you wear sunscreen? Y/N **Do you have a history of tanning salon use?** Y/N

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

Occupation and Place of Employment: _____