PATIENT MEDICAL HISTORY/EVALUATION FORM

NAME_____DATE:_____

GENDER: _____SS: _____ AGE:_____ DATE OF BIRTH: _____

REFERRING PHYSICIAN'S NAME: _____

REASON FOR VISIT/CHIEF COMPLAINT: _____

ALLERGIES TO MEDICATIONS: _____
Current Medications: _____
Major Medical Illnesses/Surgeries: _____

SOCIAL HISTORY:
Occupation: _____ Marital Status: _____
Do You Smoke? _____ Do You Use Alcohol? _____
Did you smoke in the past? _____
Are you pregnant? ___Yes ___ No

PAST MEDICAL/FAMILY HISTORY:
Check if you personally or anyone in your family has:

	Self	Family		Self	Family		Self	Family
Allergies	___	___	Hayfever	___	___	Malignant Melanoma	___	___
Arthritis	___	___	Heart Disease	___	___			
Diabetes	___	___	Hypertension	___	___	Psoriasis	___	___
Eczema	___	___	Lung Disease	___	___	Skin Cancer	___	___

Do you bleed easily? _____

REVIEW OF SYSTEMS: (Current or Past Problems):

	Normal	Abnormal	(If abnormal, explain)
General Health	___	___	_____
Allergic/Immunologic	___	___	_____
Cardiovascular	___	___	_____
Ears, Nose & Throat	___	___	_____
Eyes	___	___	_____
Gastrointestinal	___	___	_____
Genitourinary	___	___	_____
Hematologic/Lymphatic	___	___	_____
Musculoskeletal	___	___	_____
Neurologic disorder	___	___	_____
Psychiatric	___	___	_____
Respiratory	___	___	_____
Thyroid/Diabetes	___	___	_____

When you are exposed to sun, do you: __Tan only __Burn & Tan __Burn
Do you have a history of any specific skin disease? _____
If yes, please list: _____

Signed by Patient: _____ Date: _____

Signed By Physician: _____ Date: _____