Advanced Dermatology of Southeast Missouri, PC
Medical History Form

Name:_____ **DOB:**_____

Were you specifically referred by another health care provider? **Yes** **No**

If so, who referred you: _____ **Referring Provider's Number:** _____

Primary doctor: _____ **Number (if known)**_____

Pharmacy Name: _____ **Pharmacy City:** _____

Reason for Today's Visit:

_____

_____

_____

Past Medical History:

Arthritis	Asthma	Bone Marrow or Organ Transplant	Breast Cancer
COPD	Coronary Artery Disease	Depression	Diabetes
End Stage Renal Disease	GERD	Hepatitis B or C	High Blood Pressure
HIV/ AIDS	High Cholesterol	Hyperthyroidism	Hypothyroidism
Radiation Treatment	Seizures	Stroke	Immuno-suppressed

Cancer other than skin cancer. If so what type (s):_____

Other past medical history: _____

Skin Disease History:

Basal Cell Skin Cancer	**Squamous Cell Carcinoma**	**Skin cancer, not certain of type**	**Melanoma**
Blistering Sunburns	Dry Skin	Eczema	Precancerous Moles
Psoriasis	Sensitive Skin	Other:_____	

Occupation/ Type of Work: _____

(Continue on reverse side)

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Do you wear sunscreen? Yes No **Do you use tanning salons?** Yes No

Do you have a relative that has had Melanoma? Yes No **Relationship:**_____

Current Medications Please list name only. If you have a list, please skip and provide list to staff

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies to Medication: No Yes (please list on line directly below)

_____

_____

Smoking Status: Current every day smoker Current Some Day Smoker Former Smoker Never Smoked

Review of Systems:

Changing Mole	Artificial Heart Valve	Artificial Joint (s)	Pacemaker or Defibrillator
Pregnant	Breast Feeding	Allergy to Band-Aid Adhesive	Allergy to Latex
Problems with healing	Problems with scarring	Problems with bleeding	Take blood thinners
Fever	Currently swollen lymph nodes	Night sweats	Unintentional weight loss
Immuno-suppression	Rapid heartbeat with Epinephrine	Yeast infection with antibiotics	Stomach upset with antibiotics

List any diseases or conditions:

_____

_____

_____