

PAST MEDICAL FAMILY AND SOCIAL HISTORY

List allergies to any medications here:	List all your medications, vitamins and herbs here:
	Include aspirin, birth control pills, everything! Just the names, doses not needed.

Past Medical History: (*Your personal history. Enter your family's medical history in the next section*)

yes	no	unsure	Have you been treated any of the following: (specify details where asked)
			Melanoma (a life-threatening malignant mole, not a routine "skin cancer")
			Non-melanoma skin cancer such as basal cell ca (BCC), squamous cell ca (SCC)
			Dysplastic nevi (abnormal or "pre-cancerous moles" found on biopsy)
			Actinic keratoses (pre-cancerous growths, usually frozen off with nitrogen)
			Leg vein thrombosis (clots), vein stripping, or vascular surgery of the legs such as bypass
			Thyroid disease
			Bleeding disorders
			Anemia or iron deficiency
			Asthma or hay fever
			Diabetes. If yes, do you take insulin? Y / N Is your sugar under good control? Y / N
			Hypertension. If yes, is your blood pressure well-controlled? Y / N
			Artificial heart valve or murmur. If yes, do you need antibiotics for procedures? Y / N
			Artificial knee, hip or other joint. If yes, do you need antibiotics for procedures? Y / N
			Hepatitis. If yes, do you know what type? A / B / C
			Any cancer, other than skin cancer. If yes, type:
			HIV infection or AIDS. If yes, is your CD4 cell count greater than 500? Y / N
			Radiation therapy for cancer. If yes, area treated:
			Exposure to arsenic. (example, people who grew up drinking well water in Kentucky, use of Fowler's solution for treatment of asthma years ago, etc.)
			Other (specify):

Past Family History: (medical problems in closely related family members ie: your parents, siblings or children)

			Melanoma (a life-threatening malignant mole, not a routine "skin cancer")
			Dysplastic nevi (abnormal or "pre-cancerous moles" found on biopsy)
			Asthma, eczema or hay fever
			Hair loss or balding. If yes, what is the youngest age at which hair loss began?:
			Other (specify):

Personal Social History: (your living and work situation, sun exposure, etc.)

			Do you work or play outdoors extensively (many hours per week)
			Do you live alone. If no, how many people live under the same roof?:
			Are you working. If yes, what type of work do you do?:
			Does anyone else at home have the same rash or complaint your are coming here for today?

NAME: _____
 LAST, FIRST MI

DOB:

DOS:

Above reviewed by MD:

 Dean R. Goodless, M.D.