NORTHERN ARIZONA DERMATOLOGY

Patient History Checklist (Side #1)

PATIENT:_____DOB: _____/_____/_____ Date:_____/_____/_____

MEDICAL HISTORY:

Select any of the following conditions that you currently have:

___Anxiety	___COPD	___High Blood Pressure	___Prostate Cancer
___Arthritis	___Coronary Artery Disease	___HIV / AIDS	___Radiation
___Asthma	___Depression	___High Cholesterol	___Seizures
___Atrial Fibrillation	___Diabetes	___Hyperthyroidism	___Stroke
___Bone Marrow Transplant	___End Stage Renal Disease	___Hypothyroidism	
___BPH	___Gastric Reflux (GERD)	___Leukemia	
___Breast Cancer	___Hearing Loss	___Lung Cancer	
___Colon Cancer	___Hepatitis	___Lymphoma	___No Conditions To Report

Other conditions not listed:_____

Have you had any surgeries on the following organs?

___Appendix: (Appendectomy)
___Bladder (Cystectomy)
___Breast Biopsy
___Breast Lumpectomy:___Both___Left___Right
___Breast Mastectomy :___Both___Left___Right
___Colon (Colectomy): Colon Cancer Resection
___Colon (Colectomy): Diverticulitis
___Colon (Colectomy): Inflammatory Bowel Disease
___Colon: Colostomy
___Gallblader (Cholecystectomy)
___Heart: Biological Valve Replacement
___Heart: Coronary Artery Bypass
___Heart: Heart Transplant
___Heart: Mechanical Valve Replacement
___Heart: PTCA
___Joint Replacement Hips: ___Both___Left___Right
___Joint Replacement Knees: ___Both___Left___Right
___Kidney: Biopsy
___Kidney: Kidney Stone Removal
___Kidney: Kidney Transplant
___Kidney: Nephrectomy
___Liver: Hepatectomy
___Liver: Liver Transplant
___Liver: Liver Shunt
___Ovaries(Oophorectomy): Endrometriosis
___Ovaries (Oophorectomy): Ovarian Cancer
___Ovaries (Oophorectomy): Ovarian Cyst
___Ovaries : Tubal Ligation
___Pancreas: Pancreatectomy
___Prostate (Prostatectomy): Prostate Biopsy
___Prostate (Prostatectomy): Prostate Cancer
___ Prostate (Prostatectomy): TURP
___Rectum: APR
___Rectum: Low Anterior Resection
___Skin: Basal Cell Carcinoma
___Skin: Melanoma
___Skin: Biopsy
___Skin: Squamous Cell Carcinoma
___Spleen (Splenectomy)
___Testicles (Orchiectomy)
___Uterus (Hysterectomy): Uterine Cancer
___Uterus (Hysterectomy): Cervical Cancer
___Uterus (Hysterectomy): Fibroids
___Uteris (Hysterectomy): Other
___NO SURGERIES TO REPORT

PAST SURGERIES NOT LISTED:_____

Patient History Checklist (Side #2)

PRIMARY CARE PROVIDER; (PCP)_____PHONE #: _____

DERMATOLOGY HISTORY: ***PLEASE MARK ANY OF THE CONDITIONS BELOW THAT APPLY TO YOU***

_____Acne	_____Eczema	_____Atypical Moles/Precancerous
_____Actinic Keratosis / precancerous lesions	_____Flaking or itchy scalp	_____BASAL CELL CARCINOMA
_____Asthma	_____Hay Fever/Allergies	_____SQUAMOUS CELL CARCINOMA
_____Blistering Sunburns	_____Poison Ivy	_____MELANOMA
_____Dry Skin	____ Psoriasis	_____No skin conditions to report

Do you wear sunscreen? ___Yes ___No What SPF___ **Do you tan in a tanning salon? ___Yes ___No**

FAMILY HISTORY OF MELANOMA

Do you have a family history of Melanoma? ___Yes ___No

If yes, which relative(s)? (Circle all that apply) Mother Father Sister Brother Daughter Son

Any other direct relatives that may apply **_____**

FAMILY HISTORY OF *OTHER TYPES OF SKIN CANCER*

Do you have a family history of other types of skin cancer?

(i.e.) Basal cell carcinoma / Squamous Cell Carcinoma___Yes ___No

If yes, which relative(s)? (Circle all that apply) Mother Father Sister Brother Daughter Son

Any other direct relatives that may apply **_____**

MEDICATIONS: Are you currently taking prescriptions medications? ___Yes ___No

(If yes, please list below):

Name:_____Dose_____Frequency_____	Name:_____Dose_____Frequency_____
Name:_____Dose_____Frequency_____	Name:_____Dose_____Frequency_____
Name:_____Dose_____Frequency_____	Name:_____Dose_____Frequency_____
Name:_____Dose_____Frequency_____	Name:_____Dose_____Frequency_____
Name:_____Dose_____Frequency_____	Name:_____Dose_____Frequency_____

Are you currently taking any over the counter medications or supplement? ___Yes ___No

(If yes, please list below):

Name:_____Frequency_____	Name:_____Frequency_____
Name:_____Frequency_____	Name:_____ _____Frequency_____
Name:_____ _____ Frequency_____	Name:_____Frequency_____

ALLERGIES: **DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? ___Yes ___No**

*****If yes, please list the medication and the type of reaction that you experience*****

1: Medication:_____Reaction:_____

2: Medication:_____Reaction:_____

3: Medication:_____Reaction:_____

Additional Allergies to Medications & Reactions:_____

Are you allergic to: (Please mark each selection)

Lidocaine ____ Yes ___No Betadine/Iodine ___Yes ___No

Latex ____Yes ___No Neosporin ____Yes ___No

SOCIAL HISTORY: ****Please mark any that apply****

Never Smoked_____ Currently Smoke___Yes___No Have Smoked in Past___Yes___No

Drink Alcohol___Yes___No Drug Use___Yes___No IV Drug Use___Yes___No

Are you currently pregnant? ___Yes ___No Are you planning to become pregnant? ___Yes___No