HMGS DERMATOLOGY HEALTH HISTORY INTAKE FORM

Name: _____ Date of Birth: _____ MR#: _____

Primary Care Provider: _____ Address/Town: _____

Patient Email Address (for communication and online patient portal): _____

Past Medical History (please *circle* all that apply):

Anemia	CHF	Depression	Hayfever	Hypertension	Reflux/GERD
Anxiety	COPD	Diabetes	Heart Disease	Hypothyroidism	Seizures
Arthritis	Cataracts	Eczema	Hepatitis A/B/C	Hyperthyroidism	Stroke
Asthma	Clotting Problems	Glaucoma	High Cholesterol	Lupus	Ulcerative Colitis
Bleeding	Crohn's Disease	HIV	Hives	Psoriasis	Tuberculosis

Other (not listed):_____

Personal history of cancer: _____

Implants/Devices: Do you have (check all that apply): _____Artificial joint ____Pacemaker _____Defibrillator

Past Surgical History (Please list all previous surgeries):

_____

_____

_____

Personal Skin Cancer History: _____Basal Cell _____Squamous Cell _____Melanoma Other_____

Do you wear sunscreen regularly: YES or NO Have you used tanning beds: YES or NO

Do you have family history of melanoma: YES or NO If so, whom: _____

Smoking history: _____Never Smoker _____Former Smoker _____Everyday Smoker _____Some Day Smoker

Do you have any **allergies** to medications: YES or NO If yes, please list:_____

Current Medications (including dose if known, e.g. aspirin 81mg): _____

_____

_____

_____

Preferred Pharmacy: _____Address/Town/Phone:_____

Occupation:_____

Patient or Guardian Signature:_____ **Today's Date:**_____