ALTA VISTA DERMATOLOGY

206 W. County Line Road, Suite 340
Highlands Ranch, CO 80129

MEDICAL HISTORY FORM

Patient Name:_____ Date of Birth:____/____/____ Today's Date:_____

SKIN CANCER HISTORY: Have you ever had skin cancer or pre-cancer or abnormal moles: ❑ Yes ❑ No

Type of skin cancer:
- ❑ Actinic Keratosis
- ❑ Cutaneous T-cell Lymphoma
- ❑ Atypical/ abnormal mole
- ❑ Basal Cell Carcinoma
- ❑ Unknown type
- ❑ Malignant Melanoma
- ❑ Squamous Cell Carcinoma

Year Treated:_____ Body Location:_____

HISTORY OF SPECIFIC SKIN CONDITION:_____

MEDICAL HISTORY: (Please be sure to check all that apply - past or present)

- ❑ Heart
  - ❑ Artificial valves
  - ❑ Mitral valve prolapse
  - ❑ Heart murmur/ irregular heart beat
  - ❑ Rheumatic fever
  - ❑ Pacemaker/ Defibrillator
  - ❑ High blood pressure
- ❑ Joint
  - ❑ Arthritis
  - ❑ Artificial joint
- ❑ Neurological
  - ❑ Stroke
  - ❑ Multiple sclerosis
  - ❑ Seizures/ Epilepsy
  - ❑ Fainting
- ❑ Other
  - ❑ HIV disease
  - ❑ Hepatitis/ Liver disease
  - ❑ Infections, chronic
  - ❑ Lupus
  - ❑ Diabetes
  - ❑ Thyroid disease
  - ❑ Cancer:_____
  - ❑ Bleeding, excessive
  - ❑ Blood clots
  - ❑ Lung or kidney or bowel disease
  - ❑ Organ transplant
  - ❑ Depression or other psychiatric disease
  - ❑ Scarring / keloids/ slow wound healing
  - ❑ Other:_____

FEMALES: ❑ Pregnant or planning pregnancy ❑ Taking Oral Contraceptives ❑ Nursing

SURGICAL HISTORY:_____ Date:_____

ALLERGIES: Are you <u>ALLERGIC</u> to any medications: ❑ Yes ❑ No If yes, list:_____

Other known allergies:_____

CURRENT MEDICATIONS: (please list ALL prescription and over-the-counter medications, vitamins and herbals):

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY: Occupation:_____ ❑ Working ❑ Retired ❑ Disabled

Has your weight changed in the last 6 months? ❑ Yes ❑ No ____ Lbs Do you use tobacco? ❑ Yes ❑ Never ❑ Quit

Do you drink alcohol? ❑ Yes ❑ Never ❑ Quit _____ Do you use recreational drugs? ❑ Yes ❑ Never ❑ Quit

FAMILY HISTORY: (Please check the following if they have occurred in your family)

- ❑ Cancer
- ❑ Skin cancer
- ❑ Malignant melanoma
- ❑ Autoimmune disease
- ❑ Diabetes
- ❑ Arthritis
- ❑ Eczema
- ❑ Allergies
- ❑ Hay fever
- ❑ Psoriasis
- ❑ Lupus erythematosus
- ❑ Asthma

_____ _____

Signature of Patient or Legal Representative *Date*