matherne
DERMATOLOGY + AESTHETICS

PATIENT MEDICAL HISTORY

Please complete entire questionnaire by checking all that apply

Social History: [ ] Never smoker [ ]Former smoker [ ]Current some day smoker [ ] Current every day smoker

Alcohol Use: [ ] None [ ] Less than 1 drink per day [ ] 1-2 drinks per day [ ] 3 or more drinks per day

How many times in the past year have you had 5 or more drinks in a single day? _____

Past Medical History:
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation (Irregular Heartbeat)
☐ Bone Marrow Transplantation
☐ Benign Prostatic Hyperplasia
☐ Breast Cancer
☐ Colon Cancer
☐ COPD
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ End Stage Renal Disease
☐ Acid Reflux
☐ Hearing Loss
☐ Hepatitis
☐ Hypertension
☐ HIV/AIDS
☐ Hypercholesterolemia
☐ Hyperthyroidism
☐ Leukemia
☐ Lung Cancer
☐ Lymphoma
☐ Prostate Cancer
☐ Radiation Treatment
☐ Seizures
☐ Stroke
☐ None
☐ Other _____

Do you wear sunscreen?
[ ] Yes [ ] No

Do you tan in a tanning salon?
[ ] Yes [ ]No

Past Surgical History:
☐ Appendix Removal
☐ Bladder Removal
☐ Breast: Breast Biopsy
☐ Breast: Lumpectomy (Right, Left, Both)
☐ Breast: Mastectomy (Right, Left, Both)
☐ Colon Cancer Resection
☐ Diverticulitis
☐ Inflammatory Bowel Disease
☐ Colostomy
☐ Gallbladder Removal
☐ Biological Valve Replacement
☐ Coronary Artery Bypass
☐ Heart Transplant
☐ Mechanical Valve Replacement
☐ Angioplasty Surgery
☐ Hip Replacement (Right, Left, Both)
☐ Knee Replacement (Right, Left, Both)
☐ Kidney Biopsy
☐ Kidney Stone Removal
☐ Kidney Transplant
☐ Kidney Removal (Right, Left)
☐ Liver Removal
☐ Liver Transplant
☐ Liver Shunt
☐ Endometriosis
☐ Ovarian Cancer
☐ Ovarian Cyst
☐ Tubal Ligation
☐ Pancreas Removal
☐ Prostate Biopsy
☐ Prostate Cancer
☐ TURP
☐ Abdominal Perineal Resection
☐ Low Anterior Resection
☐ Spleen Removal
☐ Testicle Removal
☐ Uterine Fibroids
☐ Uterine Cancer
☐ Cervical Cancer
☐ None
☐ Other _____

Skin Disease History:
☐ Acne
☐ Actinic Keratoses
☐ Asthma
☐ Basal Cell Skin Cancer
☐ Blistering Sunburns
☐ Dry Skin
☐ Eczema
☐ Flaking or Itchy Scalp
☐ Hay Fever/Allergies
☐ Melanoma
☐ Poison Ivy
☐ Precancerous Moles
☐ Psoriasis
☐ Squamous Cell Skin Cancer
☐ None
☐ Other _____

Do you have a family history of Melanoma? [ ] Yes [ ] No
If yes, which relative?

Have you received a pneumonia vaccination?
[ ] Yes [ ] No