

Advanced Dermatology of Westchester, PLLC Medical History Form

Name: _____ Today's Date ___/___/___

Date of Birth: ___/___/___ Age: _____ Sex: Male Female

Reason for today's visit? _____

Medications Currently Being Taken (including prescriptions, aspirin, vitamins, herbals, birth control pills):

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Allergies: (medication, anesthesia or latex): _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

	YES	NO		YES	NO
Diabetes	()	()	High Blood Pressure	()	()
Heart Problems	()	()	Pacemaker	()	()
Bleeding Problems	()	()	Other _____		

Skin: YES NO

Personal history of skin cancer () () If yes, what type? _____

Family history of skin cancer/melanoma () () If yes, Who? _____

Do you have a history of any specific skin diseases? () ()

If yes, please list: _____

Do you have any new growths or changes in an existing one? _____

Do you wear sunscreen? () ()

List surgical procedures/hospitalizations you have had in the last 6 months: _____

Social History: YES NO

Do you drink alcohol? () () If yes, _____ drinks per day

Do you smoke? () ()

Have you had or have you been exposed to HIV (AIDS)? () ()

Have you had or have you been exposed to Hepatitis? () ()

What is your occupation? _____

What are your hobbies? _____

For Women Only: YES NO

Are you pregnant or trying to get pregnant? () () Due Date: _____

Are you breastfeeding? () ()

Completed by: _____ Patient signature _____ Date _____