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CENTER FOR DERMATOLOGY
ERIK B. HURST, MD

# MEDICAL HISTORY FORM

DATE _____

Name _____ Birth Date _____ Age _____

Reason for Visit: _____

**Medical History (Check all that apply and explain if needed):**

- ☐ Diabetes _____
- ☐ Kidney Disease _____
- ☐ Heart Disease _____
- ☐ Easy Bleeding or Bruising _____
- ☐ Hayfever/Allergies _____
- ☐ Liver Disease _____
- ☐ HIV/AIDS _____
- ☐ Artificial Heart Valve _____
- ☐ Mitral Valve Prolapse _____
- ☐ Depression _____
- ☐ High Cholesterol _____
- ☐ High Blood Pressure _____
- ☐ Lung Disease _____
- ☐ Cancer _____
- ☐ Hepatitis _____
- ☐ Artificial Joints _____
- ☐ Pacemaker/Defibrillator _____
- ☐ Other _____

**Skin History (Check all that apply and explain if needed. Give dates and location of skin caner):**

- ☐ Skin Cancer _____
- ☐ Melanoma _____
- ☐ Lupus _____
- ☐ Eczema _____
- ☐ Warts _____
- ☐ Keloids _____
- ☐ Atypical, dysplastic or precancerous moles _____
- ☐ Psoriasis _____
- ☐ Acne _____
- ☐ Rosacea _____
- ☐ Actinic keratosis/Precancers _____

**Family History (Check all that apply and explain if needed):**

- ☐ Skin Cancer (Basal or squamous cell): _____
- ☐ Melanoma _____
- ☐ Lupus _____
- ☐ Eczema _____
- ☐ Psoriasis _____
- ☐ Other skin condition _____

**Social History:**

Lifetime sun exposure: ☐ A little ☐ A moderate amount ☐ A lot

Do you wear sunscreen regularly: ☐ Yes ☐ No

Do you smoke cigarettes: ☐ Yes ☐ No

Do you drink alcohol: ☐ Yes ☐ No Drinks per day: _____

Are you pregnant: ☐ Yes ☐ No Due Date: _____

What is your occupation: _____

**List the names (dose not needed) of all medications you are taking:**

_____

**List any medications you are allergic to:**

_____

**Patient Signature/Date**

_____

**Medical History Reviewed by/Date**

_____