Brentwood Skin Clinic Medical History Form

Name: ________________________________ Date of Birth: __________________ Weight: ________ Height: ________

Dermatology/Skin History

◯ Acne
◯ Warts
◯ Abnormal Moles
◯ Allergies/Hay Fever
◯ Blistering Sunburns
◯ Cold Sores/Fever Blisters
◯ Seborrheic Keratosis
◯ Dry Skin
◯ Itchy or Flaking scalp
◯ Eczema
◯ Pre-Cancerous Moles
◯ Psoriasis
◯ Poison Ivy/Oak
◯ Rosacea
◯ Squamous Cell Carcinoma of Skin
◯ Basal Cell Carcinoma of Skin
◯ Malignant Melanoma
◯ Actinic Keratosis
◯ Atypical Moles
◯ Folliculitis (in grown hairs)
◯ Skin Tags

Do you wear Sunscreen? Yes or No

If yes, what SPF? ________

Do you use a tanning salon? Yes or No

Do you have a family history of Melanoma? Yes or No If yes, which family member:_________________

Smoking Status

◯ NEVER
◯ Former Smoker
◯ Chewing Tobacco
◯ Occasional Smoker
◯ Everyday Smoker
◯ E-Cigarette/Vape

If applicable

Number of Packs per day: ________

Total number of years of tobacco use: _________

Alcohol Consumption

◯ None
◯ Less than 1 drink per day
◯ 1-2 drinks per day
◯ 3+ drinks per day

Other: _____________________________________

Social History

◯ Not sexually active
◯ Sexually active with one partner
◯ Sexually active with multiple partners
◯ Patient exercise If yes, days per week ___________
◯ Patient drives during the day
◯ Patient drives at night
◯ Patient consumes caffeine If yes, # per day______
◯ **Do you, the patient, feel safe at home? YES NO**

Female Patients Only

Last menstrual cycle: _____________ Are you pregnant? Yes or No Are you breast feeding? Yes or No

Have you received the Pneumonia Vaccine? Yes or No If yes, when (age/year)? ___________

Have you received a Flu Shot this Year? Yes or No If yes, when (approximate date)? _______

Have you received the Shingle Vaccine? Yes or No If yes, when (age/year)?____________

Do you have an Advanced Care Plan? Yes No

Do you have a surrogate decision maker? Or Power of Attorney? Yes No I don't know

If yes, who- Name, Phone number and Relationship

Medical Conditions

Please describe any medical conditions that you currently have

◯ NONE
◯ Other ____

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Medications

Please list all medications you are currently taking or provide us with a copy we can scan

Drug: ____________________________ Dosage: __________ Frequency: __________ Reason____________________

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Drug: ____________________________ Dosage: __________ Frequency: __________ Reason____________________

Allergies

Please list al known allergies (environment, drug, food) as well as the type of reaction and level of severity

◯ NONE
◯ Other ____

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Skin Related Surgeries or anything else you would like to disclose:

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