Scholes Dermatology- Medical History

Name____ Date of Birth______________________

Medical History: Do you now have (or have had in the past) and the following conditions? Please check all that apply:

- o Anxiety
- o Arthritis (Osteo)
- o Arthritis (RA)
- o Asthma
- o Atrial Fibrillation/ Irregular Heartbeat
- o Bone Marrow Transplant
- o Breast Cancer
- o Colon Cancer
- o COPD
- o Depression
- o Diabetes
- o Gastric Reflux (GERD)
- o Hearing Loss
- o Heart Disease
- o Hepatitis Type______
- o High Blood Pressure
- o HIV/AIDS
- o High Cholesterol
- o Kidney Disease
- o Leukemia
- o Lung Cancer
- o Lymphoma
- o Pacemaker
- o Prostate Cancer
- o Radiation Treatment
- o Seizures
- o Stroke
- o Thyroid
- o Other disease not listed ______________________

Surgical History: Please check all that apply to you:

- o **No Previous Surgeries**
- o Appendix
- o Bladder Removal
- o Breast Biopsy
- o Breast Lumpectomy (Left)
- o Breast Lumpectomy (Right)
- o Breast Mastecotmy (Left)
- o Breast Mastectomy (Right)
- o Colon Surgery (Cancer)
- o Colon Surgery (Diverticulitis)
- o Colon Surgery (UC/Crohn)
- o Gall Badder
- o Heart Bypass (CABG)
- o Heart Stent
- o Heart Transplant
- o Heart Valve (Mechanical)
- o Heart Valve (biological)
- o Heart: PTCA
- o Hip Replacement (Left)
- o Hip Replacement (Right)
- o Knee Replacement (Left)
- o Knee Replacement (Right)
- o Kidney Biopsy
- o Kidney Transplant
- o Liver Transplant
- o Liver Shunt
- o Prostate Biopsy
- o Prostate Cancer
- o Prostate TURP
- o Oophorectomy (Cyst-Ovary)
- o Oophorectomy (Cancer- Ovary)
- o Rectum Resection
- o Skin Biopsy
- o Melanoma
- o Spleen (Splenectomy)
- o Testicles (Orchiectomy)
- o Hysterectomy (Fibroids)
- o Hysterectomy (Uterine Cancer)
- o Hysterectomy (Cervical Cancer)
- o Other surgeries not listed ____________________

Skin Disease History: Please check all that apply to you:

- o Acne
- o Actinic Keratoses
- o Asthma
- o Blistering Sunburns
- o Dry Skin
- o Eczema
- o Flaking or Itchy Scalp
- o Hay fever/ Allergies
- o Melanoma
- o Poison Ivy
- o Psoriasis
- o BCC- Where?___________
- o SCC- Where?___________

- o Other skin problems not listed:____

Do you wear sunscreen? Yes No What SPF? ______ Do you tan in a tanning salon? Yes No

Do you have a family history of Skin Cancer? Who?_________________________

Does anyone in your family have a history of Melanoma? Who?_________________________