WEST MICHIGAN DERMATOLOGY
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MEDICAL HISTORY FORM

DATE: _____ **NAME:** _____
Last First Middle Initial

BIRTHDATE: __/__/____ **BIRTHPLACE:** _____
City State Country

PLEASE MARK ANY OF THE MEDICAL CONDITIONS THAT YOU HAVE OR HAVE HAD

- ☐ **NONE**
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular heartbeat)
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hepatitis-Type _____
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroidism (High)
- ☐ Hypothyroidism (Low)
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke

OTHER pertinent:

- ☐ Alzheimer's Disease
- ☐ DVT / PE
- ☐ Glaucoma
- ☐ Gout
- ☐ Pacemaker
- ☐ Tuberculosis

PLEASE MARK ANY SURGERIES YOU HAVE HAD

- ☐ **NONE**
- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Breast – Biopsy
- ☐ Breast - Implants
- ☐ Breast – Lumpectomy ☐ right ☐ left ☐ both
- ☐ Breast – Mastectomy ☐ right ☐ left ☐ both
- ☐ Colon ☐ Colon Cancer Resection ☐ Diverticulitis ☐ Inflam. Bowel Disease ☐ Colostomy
- ☐ Gallbladder Removed
- ☐ Heart – Biological Valve Replacement
- ☐ Heart – Coronary Artery Bypass Surgery
- ☐ Heart – Heart Transplant
- ☐ Heart – Mechanical Valve Replacement
- ☐ Heart – PTCA
- ☐ Joint Replacement-Hip ☐ right ☐ left ☐ both
- ☐ Joint Replacement-Knee ☐ right ☐ left ☐ both
- ☐ Liver ☐ Hepatectomy ☐ Liver Transplant ☐ Shunt
- ☐ Ovaries removed: due to ☐ Endometriosis ☐ Ovarian Cancer ☐ Ovarian Cyst ☐ Tubal Ligation
- ☐ Pancreas – Pancreatectomy
- ☐ Prostate – ☐ Biopsy ☐ Cancer ☐ TURP
- ☐ Rectum – APR
- ☐ Rectum – Low Anterior Resection
- ☐ Skin ☐ Basal Cell Carcinoma ☐ Melanoma ☐ Skin Biopsy ☐ Squamous Cell Carcinoma
- ☐ Spleen – Removed
- ☐ Testicles – Removed
- ☐ Uterus – Hysterectomy due to ☐ Fibroids ☐ Uterine Cancer ☐ Cervical Cancer
- ☐ OTHER _____
- ☐ OTHER _____

PLEASE MARK ANY SKIN CONDITIONS YOU HAVE OR HAVE HAD

☐ **NONE**
☐ Acne
☐ Actinic Keratosis
☐ 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

OTHER PERTINENT
☐ Alopecia
☐ Keloid Scars
☐ Shingles/Chicken Pox
☐ Vitiligo
☐ Warts

Do you wear sunscreen? ☐ Yes ☐ No If **YES**, what SPF? ☐ 15 ☐ 30 ☐ 45 ☐ 50
Do you tan in a tanning salon? ☐ Yes ☐ No
Do you have a family history of Melanoma? Yes No
If **YES**, which relative(s)? ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
☐ Uncle ☐ Aunt ☐ Nephew ☐ Niece
☐ Grandmother ☐ Grandfather ☐ Grandson ☐ Granddaughter

SOCIAL HISTORY: (Please check all that apply)

SMOKING STATUS:
☐ Current Everyday Smoker
☐ Current Some Day Smoker (tobacco)
☐ Current Some Day Smoker (cigarette)
☐ Former Smoker
☐ Never Smoker
☐ Cigar Smoker

ALCOHOL USE:
Do you drink alcohol ☐ Yes ☐ No

How many times in the past year have you had:
MEN: 5 or more drinks in one day? ____
WOMEN: 4 or more drinks in one day? ____
OVER 65: 4 or more drinks in one day? ____

FAMILY HISTORY OF ILLNESS—(If yes please state which relative)

Have any of your **first degree relatives** ever been diagnosed with:

- **Acne** ☐ No ☐ Yes, relative _____
- **Allergies** ☐ No ☐ Yes, relative _____
- **Asthma** ☐ No ☐ Yes, relative
- **Eczema** ☐ No ☐ Yes, relative _____
- **Hay Fever** ☐ No ☐ Yes, relative _____
- **Lupus Erythematosus** ☐ No ☐ Yes, relative _____
- **Melanom**a ☐ No ☐ Yes, relative _____
- **Other malignant neoplasm of skin (Basal Cell Carcinoma)** ☐ No ☐ Yes, relative_____
- **Psoriasis** ☐ No ☐ Yes, relative _____
- **Scleroderma?** ☐ No ☐ Yes, relative _____
- **Squamous Cell Skin Cancer** ☐ No ☐ Yes, relative _____

OTHER: _____ relative _____

☐ **No Family History of Malignancy/Cancer**