WEST MICHIGAN DERMATOLOGY WWW.WESTMICHIGANDERM.COM

Your Home for Compassionate Service and Exceptional Care

PATIENT NAME: ____ **DATE OF BIRTH:** ______________

Height: _______________________ **Weight:** ______________

Please list any new medical conditions or changes that have occurred in the past year: __________________

____

____

MEDICAL HISTORY:

Please mark any past or present medical conditions:

- ☐ Autoimmune (Lupus, MS, RA)
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (irregular heartbeat)
- ☐ Bone Marrow Transplant
- ☐ Cancer (type)_________________
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ Heartburn / GERD / Acid Reflux
- ☐ Heart Disease
- ☐ Hepatitis Viral (B or C)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV / AIDS
- ☐ Inflammatory Bowel Disease (crohns or ulcerative colitis)
- ☐ Organ Transplant (solid)
- ☐ Overactive Thyroid (high)
- ☐ Underactive Thyroid (low)
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ **NONE**

Please list any additional medical conditions: ____

____

____

Please list any major surgeries with dates (if known): ____

____

____

SKIN CONDITIONS:

Please mark any past or present skin conditions:

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell Skin Cancer
- ☐ Bleeding / Bruising
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema / Psoriasis
- ☐ Flaky or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Precancerous or atypical moles
- ☐ Squamous Cell Skin Cancer
- ☐ NONE
- ☐ Other: ______________________________
  ** Please Specify**

MELANOMA:

Do you have a history of melanoma? ☐ YES ☐NO Can you provide additional details (lymph node status, metastatic, etc.) ____

Do any of your blood relatives have melanoma? ☐ YES ☐NO Relationship: __________________________

SUN SAFETY:

Do you wear sunscreen? ☐ YES ☐ NO If yes, what SPF? ______. Do you tan in a tanning bed? ☐ YES ☐ NO

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SOCIAL HISTORY:

Current Smoker:	☐ tobacco	☐ cigarette	☐ vape	
Former Smoker:	☐ tobacco	☐ cigarette	☐ vape	
Never Smoked	☐			
Alcohol Consumption:	☐ none	☐ less than 1 drink per day	☐ 1-2 drinks a day	☐ 3+ drinks a day

NAME OF YOUR PREFERRED PHARMACY: ____________________________ PHONE #: _____________________

ADDRESS OF PHARMACY: (and cross street if known): ____

Some medication information can be imported electronically from your pharmacy. Do we have permission to initiate an electronic import of your medication history? ☐ **YES**

MEDICATIONS AND SUPPLEMENTS:

MEDICATIONS	DOSAGE	FREQUENCY

ALLERGIES	REACTION

MEDICAL QUESTIONNAIRE:

YES	NO	
☐	☐	**Problems with healing**
☐	☐	**Problems with scarring (hypertrophic or keloids)**
☐	☐	**Difficulty with antibiotics**
☐	☐	**Enlarged lymph nodes**
☐	☐	**Immunosuppression (weakened immune system)**
☐	☐	**Taking a blood thinning medication**
☐	☐	**Allergy to adhesive / adhesive tape**
☐	☐	**Allergy to topical antibiotic ointments**
☐	☐	**Require antibiotics prior to procedures**

YES	NO	
☐	☐	**Artificial heart valve**
☐	☐	**Artificial joints**
☐	☐	**Pacemaker or defibrillator**
☐	☐	**History of organ transplant**
☐	☐	**Pregnant**
☐	☐	**Breastfeeding**
☐	☐	**HIV Positive**
☐	☐	**Viral Hepatitis**

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Patient or authorized representative signature **Date**