

Trident Dermatology

PATIENT HISTORY (REV 4/21)

Date: _____

Patient's Name: _____ DOB: _____ Age: _____ Sex: M / F

Who is your primary care provider? _____

Past Medical History:

- Have you had an **Artificial Joint** procedure within the last 2 years? Yes No
- Have you **EVER** had an **Artificial Valve Replacement**? Yes No
- Do you have a **Defibrillator**? Yes No
- Do you have a **Pacemaker**? Yes No

Have you ever had any of the following:

<input type="checkbox"/> Acne	<input type="checkbox"/> Actinic keratosis (pre-cancers)	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Basal cell skin cancer	<input type="checkbox"/> Blistering sunburns
<input type="checkbox"/> Bone Marrow Transplant	<input type="checkbox"/> BPH	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Colon Cancer
<input type="checkbox"/> COPD	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Renal Disease	<input type="checkbox"/> GERD	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hyperthyroid
<input type="checkbox"/> Hypothyroid	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Lung Cancer	<input type="checkbox"/> Lymphoma
<input type="checkbox"/> Prostate Cancer	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Seizures	<input type="checkbox"/> Stroke
<input type="checkbox"/> Dry skin	<input type="checkbox"/> Eczema	<input type="checkbox"/> Flaking or itchy scalp	<input type="checkbox"/> Hay fever/allergies
<input type="checkbox"/> Melanoma	<input type="checkbox"/> Poison Ivy	<input type="checkbox"/> Pre-cancerous moles	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Squamous cell skin cancer	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

Do you have any kidney or liver problems that could affect medications you may be prescribed? Yes No

Do you require antibiotics before surgery or dental procedures? Yes No

Do your scars make unusual thick bumps called keloids? Yes No

Females only:

Are you pregnant? Y / N If yes, _____ months?

Are you planning to become pregnant in the near future? Yes No

Do you have a **Family History** of Melanoma? Y / N If yes, which relative? _____

Do you have a **Family History** of other skin cancers? Y / N If yes, which relative? _____

Surgical History: (Please list all **MAJOR** surgeries you've had)

1.	2.
3.	4.

Medications: (Please list all meds you are currently taking with the dosage)

Medication	Dosage	Medication	Dosage

What medications are you allergic to? _____