

MEDICAL HISTORY

Patient Name: _____ DOB: _____ Date: _____

Were you referred to our office? no yes, Referring Dr. _____

Reason for visit: _____

List any medication/food allergy: _____

List all medications, including non-prescription and herbal medicines you are currently taking: _____

Are you pregnant? not applicable no yes Planning a pregnancy? not applicable no yes

Social history:

Occupation: _____ Hobbies: _____

Do you smoke? no yes, _____ per day. Drink alcohol? no yes, _____ day/wk

Review of systems/Personal medical history: Do you have, or ever had diseases/disorders of the following:

Eyes/Ears/Nose/Throat	<input type="checkbox"/> no <input type="checkbox"/> yes	Blood system/clotting	<input type="checkbox"/> no <input type="checkbox"/> yes
Heart	<input type="checkbox"/> no <input type="checkbox"/> yes	Blood sugar/diabetes	<input type="checkbox"/> no <input type="checkbox"/> yes
Lungs	<input type="checkbox"/> no <input type="checkbox"/> yes	Seizures	<input type="checkbox"/> no <input type="checkbox"/> yes
Stomach/bowel	<input type="checkbox"/> no <input type="checkbox"/> yes	Depression	<input type="checkbox"/> no <input type="checkbox"/> yes
Kidneys	<input type="checkbox"/> no <input type="checkbox"/> yes	Thyroid	<input type="checkbox"/> no <input type="checkbox"/> yes
Joints/muscles	<input type="checkbox"/> no <input type="checkbox"/> yes	Blood pressure	<input type="checkbox"/> no <input type="checkbox"/> yes
Liver	<input type="checkbox"/> no <input type="checkbox"/> yes	Lymph nodes	<input type="checkbox"/> no <input type="checkbox"/> yes
Immune system	<input type="checkbox"/> no <input type="checkbox"/> yes	Reproductive organs	<input type="checkbox"/> no <input type="checkbox"/> yes

Please explain any yes answers: _____

Family Medical History: Please list any diseases/disorders (ex. Diabetes, Thyroid, Autoimmune, etc.)

Surgical history: List any surgical procedures you have had and date of the surgery

Do you develop thick scars following trauma, surgery? no yes

Do you have any history of skin cancer? no yes

If yes, what type? _____

Do you have a history of a specific skin disease? no yes

If yes, what type? _____

Is there a family history of skin cancer (basal cell, squamous cell, melanoma) no yes

If yes, please specify how the family member is related to you _____

If yes, what type of skin cancer? _____

Thomas W. Rohde, M.D.

Julie M. Preston, PA-C

Date