Bala Dermatology

COMPLETE EVERY 6 MONTHS

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PAST MEDICAL HISTORY FORM

Name: _____

Date: _____

1. Please list all medications that you are currently taking. ▢ No medications

   _____

   _____

2. Are you allergic to any medication? Please list. ▢ No allergies

   _____

Medical History (Select any of the following medical conditions that you currently have)

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Depression
- ❑ Diabetes
- ❑ Hearing Loss
- ❑ Hepatitis Type: _____
- ❑ High Cholesterol
- ❑ High Blood Pressure
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Seizures
- ❑ Stroke
- ❑ Problems with bleeding
- ❑ Problems with healing
- ❑ Hay fever/other allergies
- ❑ Immunosuppression
- ❑ Headaches
- ❑ Heart problems
- ❑ Abdominal pain
- ❑ Kidney/urinary problems
- ❑ Artificial Joints(specify joint/year): _____
- ❑ Shortness of breath
- ❑ Heart attack
- ❑ Defibrillator
- ❑ Pacemaker
- ❑ Implantable Devices
- ❑ Other Cancer (Not of Skin): _____
- ❑ Other (List below) _____

Skin Cancer:

- ❑ Basal Cell Carcinoma
- ❑ Squamous Cell Carcinoma
- ❑ Melanoma

Family history of:

1. **Melanoma** ▢ Yes ▢ No **Relative:**
2. **Non-Melanoma skin cancer:** ▢ Yes ▢ No **Relative:**

Social History

1. Do you drink alcohol? ▢ Yes ▢ No ▢ Daily ▢ Occasionally ▢ Rarely
2. Do you smoke? ▢ Yes ▢ No ▢ Former/Quit ▢ Daily ▢ Occasionally Packs per day: _____

Have you recently had a flu vaccine? ▢ Yes ▢ No

For Patients 65 years of age and older:

Have you had a pneumonia vaccine in the past 5 years ▢ Yes ▢ No

Do you have a living will or advance medical directive? ▢ Yes ▢ No