ESSENTIALDERM
Essential Dermatology, PLLC
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Medical History Form

Patient name: _____ Chosen name/nickname: _____
First Middle Last DOB: _____
Home address: _____
Email:_____ include me on e-mail list for practice updates □ YES
Phone (Circle: Home/Work/Cell): _____ May we leave messages? □ YES □NO
Gender identity (M/F/Other): _____Pronouns: _____ Sexual orientation: _____
Marital/relationship status (Circle): Single / Married / Divorced / Widowed / Separated /Other
Pharmacy name: _____ City: _____
Primary Care Provider: _____

Emergency Contact/Parent/Guardian/Next of Kin Information
Name:_____ Phone # _____
Relationship: _____ Can we contact on your behalf: YES NO

What is the primary reason for the visit: _____

ALLERGIES: List allergies to food and/or medications:
_____
_____
_____
_____

CURRENT MEDICATIONS: List on PAGE 2 of this form

Past History	**(Circle Selection)**	
1. Have you ever had skin cancer:	YES	NO
a. If YES, was it MELANOMA:	YES	NO
2. Do you have a family history of skin cancer:	YES	NO
a. If YES, family history of MELANOMA:	YES	NO
3. Do you have a bleeding disorder:	YES	NO
4. Do you have a pacemaker:	YES	NO
5. Do you take a blood thinner:	YES	NO
6. Do you have a history of		
a. Tanning bed use	YES	NO
b. Radiation therapy	YES	NO
c. PUVA treatment	YES	NO
d. Organ transplantation	YES	NO
e. Immunosuppressive therapy	YES	NO
7. Do you have replaced joints and/or heart valve(s):	YES	NO

8. What major medical problems are you being monitored for on a regular basis:

_____

_____

Melanoma History: Please answer *ONLY* if you have a history of MELANOMA

1. Is this being monitored by another clinician presently: YES NO
2. Do you have a regularly scheduled follow-up appointment to monitor the melanoma: YES NO
3. Has an imaging test (X-RAY, CT-SCAN etc) been ordered for the melanoma: YES NO

Social History

Do you smoke: YES NO

If you ARE a smoker, CIRCLE your Current age Age 21y + Younger than 21y

WOMEN ONLY:

Are you pregnant: YES NO

Review of Symptoms:

Explain if you have current or former problems with the following:

Eyes/Glaucoma/Cataracts:	NO	YES: _____
Ears/Nose/Throat/Mouth:	NO	YES: _____
Heart / Blood pressure:	NO	YES: _____
Lungs / Asthma:	NO	YES: _____
Stomach / Gastrointestinal:	NO	YES: _____
Kidneys:	NO	YES: _____
Arthritis / Muscles / Joints:	NO	YES: _____
Headache/Stroke:	NO	YES: _____
Anxiety/Depression:	NO	YES: _____
Thyroid/Diabetes/Endocrine:	NO	YES: _____
Anemia/Bleeding:	NO	YES: _____
Hepatitis/HIV/Tuberculosis	NO	YES: _____

I have reviewed all information on this form. Patient/Guardian Signature: _____

CURRENT MEDICATION LIST: *List Medication, Dose, & Frequency*