Peak Dermatology

2009 W. Littleton Blvd. Suite 100
Littleton, CO 80120

Medical History Form

Patient Name: ______________________________ Date of Birth: ________________ Today's Date: __________

SKIN CANCER HISTORY: Have you ever had skin cancer or abnormal moles: ☐ Yes ☐ No

Type:
- ☐ Atypical/abnormal mole
- ☐ Malignant Melanoma
- ☐ Actinic Keratosis
- ☐ Basal Cell Carcinoma
- ☐ Squamous Cell Carcinoma
- ☐ Mycosis Fungoides
- ☐ Unknown type

Year Treated: ____________________ Body Location: ____

HISTORY OF SPECIFIC SKIN CONDITION: ____

MEDICAL HISTORY: (Please check all that apply-past of present)

- ☐ Heart
  - ☐ Artificial valve
  - ☐ Mitral valve prolapse
  - ☐ Heart murmur/irregular heart beat
  - ☐ Rheumatic fever
  - ☐ Pacemaker/Defibrillator
  - ☐ High blood pressure
- ☐ Joint
  - ☐ Arthritis
  - ☐ Artificial joint
- ☐ Neurological
  - ☐ Stroke
  - ☐ Multiple sclerosis
  - ☐ Seizures/Epilepsy
  - ☐ Fainting
- ☐ Other: ________________________________
- ☐ Other
  - ☐ HIV
  - ☐ Hepatitis/Liver disease
  - ☐ Infections, chronic
  - ☐ Lupus
  - ☐ Diabetes
  - ☐ Thyroid disease
  - ☐ Cancer: ____________________
  - ☐ Bleeding, excessive
  - ☐ Blood clots
  - ☐ Lung, kidney or bowel disease
  - ☐ Organ transplant
  - ☐ Depression
  - ☐ Psychiatric disease
  - ☐ Abnormal scarring/ keloids

FEMALES ☐ Pregnant or planning pregnancy ☐ Taking Oral Contraceptives ☐ Nursing

SURGICAL HISTORY: ____

ALLERGIES: Are you ALLERGIC to any medications: ☐ YES ☐ NO
If yes, list: ____

CURRENT MEDICATIONS: (Please list ALL prescription and over-the-counter medications, vitamins, and herbals)

____ ____
____ ____
____ ____

SOCIAL HISTORY: Occupation: ________________________ ☐ Retired ☐ Disabled
Do you use tobacco? ☐ Yes ☐ No ☐ Quit Do you drink alcohol? ☐ Yes ☐ No ☐ Quit
Do you use recreational drugs? ☐ Yes ☐ No ☐ Quit

FAMILY HISTORY: (Please check the following it they have occurred in your family)

- ☐ Cancer
- ☐ Autoimmune Disease
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin Cancer
- ☐ Diabetes
- ☐ Allergies
- ☐ Lupus
- ☐ Arthritis
- ☐ Malignant Melanoma
- ☐ Hay fever
- ☐ Asthma

____ ____________________
Signature of Patient or Legal Representative **Date**