

MEDICAL HISTORY

Patient: _____ **Reason for visit:** _____ **Appointment Date:** _____

Previous patient of: Dr. Carol Currey Dr. Robert DeAngelis

Please list any medications, herbal supplements and/or vitamins you are currently taking: Not taking any medications

Do you have or have you had any of the following? (if yes, please check) None

- | | | |
|---|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Cold sores/herpes | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Depression | <input type="checkbox"/> Seasonal allergies/asthma |
| <input type="checkbox"/> Artificial joints or metal implant | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin Cancer (melanoma) |
| <input type="checkbox"/> Atopic Dermatitis | <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Skin Cancer (basal/squamous cell carcinoma) |
| <input type="checkbox"/> Atypical moles | <input type="checkbox"/> HIV | <input type="checkbox"/> Skin Pre-Cancers (actinic keratoses) |
| <input type="checkbox"/> Autoimmune disease (lupus, rheumatoid arthritis) | <input type="checkbox"/> Keloids or scarring problems | <input type="checkbox"/> Thyroid trouble |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Ulcers (stomach) |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Liver disease or hepatitis | <input type="checkbox"/> Other conditions |
| | <input type="checkbox"/> Lung disease | Please list: _____ |

Female patients (check all that apply): I am pregnant nursing planning to become pregnant in the near future

Are you allergic to any medications/anesthetics? Yes No
(if yes, please list)

Please list major surgeries/hospitalizations:

_____ Date: _____ _____ Date: _____
_____ Date: _____ _____ Date: _____

Please list IMMEDIATE FAMILY that have had any of the following (mother, father, maternal or paternal grandmother or grandfather, brother, sister):

- | | |
|--|---|
| <input type="checkbox"/> Skin Cancer-Melanoma: _____ | <input type="checkbox"/> Psoriasis: _____ |
| <input type="checkbox"/> Skin Cancer-Other: _____ | <input type="checkbox"/> Eczema: _____ |
| <input type="checkbox"/> Other Cancers: _____ | <input type="checkbox"/> Other: _____ |

Your Occupation: _____
(please specify)

- | | |
|---|---|
| Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you use sunscreen on a daily basis? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you use smokeless tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you traveled outside the U.S. in past 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had at least one blistering sunburn? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you use recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever used a tanning bed? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Do you currently use a tanning bed? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Have you RECENTLY had any of the following? (Please check all that apply) None

- | | | | |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> Other skin complaints | <input type="checkbox"/> Fever/chills/weight change | <input type="checkbox"/> Itching | <input type="checkbox"/> Joint Aches |
| <input type="checkbox"/> Other systemic complaints | <input type="checkbox"/> Sun sensitivity | <input type="checkbox"/> Muscle Aches | <input type="checkbox"/> Ringing in ears |

Thank you for taking the time to help us give you the highest quality care.