RSC ROSWELL SKIN CENTER

Medical History

Name_____ **Date of Birth**_____

Reason for visit: _____

Preferred Pharmacy: _____

Primary Care Physician: _____

Allergies:

_____ _____ _____

_____ _____ _____

Medications: (ok to just provide a separate list if you have one, or we can often pull pharmacy records)

_____ _____ _____

_____ _____ _____

Medical Problems:

__Skin Cancer: (type)_____

__Diabetes	__High Blood Pressure	__Kidney Disease	__Liver Disease / Cirrhosis
__COPD	__Heart Failure	__Dialysis	__Hepatitis (A / B / C)
__Asthma	__Heart Attack	__DVT/PE (Blood Clots)	__Rheumatoid Arthritis
__Anemia	__Stroke	__Atrial Fibrillation (Afib)	__Psoriasis
__Sleep Apnea	__High Cholesterol	__Depression	__Eczema
__Dementia	__Thyroid (low / high)	__Anxiety	__Acne
__Cancer: (type)_____		__Other: _____	

Surgeries:

__Gallbladder	__Heart Bypass (CABG)	__Hernia repair	__Other: _____
__Appendectomy	__Heart Stent	__Hysterectomy	_____
__Tonsillectomy	__Pacemaker/Defibrillator	__Joint Replacement	_____

Family History:

____Melanoma ____Other skin cancer or skin problem _____

Tobacco use:

____Never
____Quit (year_____)
____Current smoker (# packs per day_____)
____Chewing tobacco

Alcohol Intake:

___None ___Occasional ___Regular

Occupation: _____

Marital status: __Married __Single __Divorced __Separated __Widowed