Paducah Dermatology, PLLC

Patient History Form

Date_____ **REFERRING PROVIDER**_____

Name _____ **Birth Date**_____ **Age**_____ (circle one) Male Female

Females: Pregnant? Yes ☐ No ☐ (Weeks____) Trying to become pregnant? Yes ☐ No ☐

Drug Allergies

List name of drug(s) below	What type of allergic reaction?

Current Medications:

Name of Medications (Prescribed and Herbal)	Dosages	Start Date

Preferred Pharmacy and Location_____

Primary Care Provider _____ Height_____ Weight_____

History of Present Illness

Problem 1: _____

- Location_____
- Duration_____
- Treatment: ☐ None_____
  - ☐ OTC _____
  - ☐ Prescription_____

- Symptoms & Severity
  - ☐ None
  - ☐ Itching - mild / mod / severe
  - ☐ Pain - mild / mod / severe
  - ☐ Bleeding - mild / mod / severe
  - ☐ Other_____

- Growths / Moles (not for Rashes)
  - ☐ Changing Colors
  - ☐ Enlarging
  - ☐ Changing Shape
  - ☐ No Change

Comments _____

Problem 2: _____

- Location_____
- Duration_____
- Treatment: ☐ None_____
  - ☐ OTC _____
  - ☐ Prescription_____

- Symptoms & Severity
  - ☐ None
  - ☐ Itching - mild / mod / severe
  - ☐ Pain - mild / mod / severe
  - ☐ Bleeding - mild / mod / severe
  - ☐ Other_____

- Growths / Moles (not for Rashes)
  - ☐ Changing Colors
  - ☐ Enlarging
  - ☐ Changing Shape
  - ☐ No Change

Comments _____

Problem 3: _____

- Location_____
- Duration_____
- Treatment: ☐ None_____
  - ☐ OTC _____
  - ☐ Prescription_____

- Symptoms & Severity
  - ☐ None
  - ☐ Itching - mild / mod / severe
  - ☐ Pain - mild / mod / severe
  - ☐ Bleeding - mild / mod / severe
  - ☐ Other_____

- Growths / Moles (not for Rashes)
  - ☐ Changing Colors
  - ☐ Enlarging
  - ☐ Changing Shape
  - ☐ No Change

Comments _____

Family History (parents, siblings, grandparents) (check appropriate box)

☐ Asthma ☐ (COPD) Lung Disease ☐ Eczema ☐ Hay Fever (seasonal allergies) ☐ Psoriasis
☐ Stroke ☐ Cancer: Type_____
☐ Skin Cancer: ☐ Basal Cell CA ☐ Squamous Cell CA ☐ Melanoma
☐ None ☐ Other_____

Social History (check appropriate box)

Occupation (Job)_____

☐ Tobacco Use - How many packs per day?_____ ☐ Former Smoker, Year Quit_____
☐ Alcohol Use - How much per day?_____

Skin Cancer and Sun Exposure History (check appropriate box)

☐ Sun Exposure: ☐ Work Outdoors ☐ Outdoor Recreation ☐ Tanning Beds
☐ Basal Cell Carcinoma_____Site_____Date_____ ☐ Multiple BCC _____
☐ Squamous Cell Carcinoma_____Site_____Date_____ ☐ Multiple SCC_____
☐ Melanoma_____

Medical History (check appropriate box)

☐ Anemia	☐ Headaches	☐ Lung Disease
☐ Arthritis	☐ Hepatitis	☐ Lupus
☐ Asthma	☐ Herpes (Fever Blisters)	☐ Neurological Disease
☐ Bleeding Problems	☐ Hives	☐ Organ Transplant
☐ Coronary Artery Disease (Heart Disease)	☐ HIV Positive	☐ Psoriasis
☐ Diabetes	☐ Hypertension (High Blood Pressure)	☐ Seizure
☐ Eczema	☐ Keloids (Thick Scars)	☐ Thyroid
☐ Hay Fever	☐ Kidney Disease	☐ Cancers - Other than skin: Type_____ Date_____

Surgical History (check appropriate box)

☐ Appendectomy (Appendix) ☐ Coronary Bypass Surgery ☐ Gallbladder
☐ Hip Replacement - Right or Left ☐ Knee Replacement - Right or Left ☐ Mastectomy (breast removed)
☐ PE Tubes (tubes in ears) ☐ Tonsillectomy (tonsils)
☐ Other _____

Immunizations (Shots) and Last Date Received

☐ Flu_____ ☐ Pneumonia_____
☐ Tetanus_____
☐ Required Childhood Shots (if applicable)_____

_____ _____
Signature Date