SKIN CARE AND LASER
PHYSICIANS OF BEVERLY HILLS
GENERAL AND COSMETIC DERMATOLOGY

# Medical History

Name (last, first)________________________________________________ Date____________

How were you referred to our practice?___________________________________________________

Did your physician request that you have a consultation with a dermatologist regarding a specific condition?

☐ yes ☐ no If yes, for what specific condition?___________________________________

What is the purpose for your visit today?__________________________________________________

**PAST HISTORY:** Do you have a history of any of the following conditions? (*check if yes)*

| | | | |
|---|---|---|---|
| ☐ HIGH BLOOD PRESSURE | ☐ DIABETES | ☐ HEPATITIS | ☐ HAY FEVER |
| ☐ HEART DISEASE | ☐ LUNG DISEASE | ☐ LIVER PROBLEMS | ☐ THYROID DISEASE |
| ☐ PACEMAKER | ☐ ARTIFICIAL JOINTS | ☐ ASTHMA | ☐ CANCER |
| ☐ ARTIFICIAL VALVES | ☐ STOMACH (ULCERS,ETC.) | ☐ ECZEMA | ☐ HIV |

☐ OTHER______________________________________________________________________

Are you allergic to any medications?______________________________________________

Please list any medications you currently use (including over the counter):

________________________ ________________________ ________________________

________________________ ________________________ ________________________

________________________ ________________________ ________________________

Please list any surgical procedures or hospitalizations with dates:___________________________

______________________________________________________________________________

**FAMILY HISTORY:** Does any member of your family have a history of skin cancer or severe skin disease?

☐ yes ☐ no *Please describe:* ________________________________________________

**SOCIAL HISTORY:** What is your occupation? ______________________________________________

Relationship status: ☐ Single ☐ Married ☐ Significant Other

Do you smoke? ☐ yes ☐ no
Do you tan often? ☐ yes ☐ no
Do you wear sunblock daily? ☐ yes ☐ no

**SYSTEMS REVIEW:** Have you recently experienced any of the following? (*check if yes)*

| | | | |
|---|---|---|---|
| ☐ fever, weight loss | ☐ muscle pain/weakness | ☐ chest pains, palpitations | ☐ pregnancy |
| ☐ difficulty breathing | ☐ joint pain/weakness | ☐ urination difficulty/pain | ☐ diarrhea |
| ☐ vision problems | ☐ neurological problems | ☐ psychiatric problems | ☐ infection |
| ☐ abdominal pain | ☐ other:____________________ | | |

*Please describe:*______________________________________________________________

An annual full body skin examination to detect melanoma and other skin cancer is recommended. There is no additional charge for this exam over the initial office visit charge. The exam is performed with a gown and undergarments on. Please indicate if you want this exam performed. ☐ yes ☐ no