DERMATOLOGY PATIENT HISTORY FORM – DR. CRIDER

BOONSLICK MEDICAL GROUP, INC.

Name:_____ Age: _____ Date of Birth: _____

Legal Guardian's Name (if patient under age 18):_____

Referring Physician (if applicable):_____

Primary Care Physician (if different from referring): _____

Reason for Dermatology Visit:_____

Medication Allergies: _____

Preferred Pharmacy (Name/Address):

_____

Personal Skin Cancer History:

Basal Cell: ___Y ___N *Squamous Cell*: ___Y ___N *Melanoma*: ___Y ___N *Other Type*: _____

Details of Skin Cancers If Known (Year Diagnosed/Body Location/Treatment/Treating Provider):

_____

_____

_____

Family History of Skin Cancer: _____

Current Medications/Doses:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medical Problems (including skin problems):

_____ _____

_____ _____

_____ _____

_____ _____

Surgical History (include year of surgery):

_____ _____

_____ _____

_____ _____

Social History:

Never smoked ____

Used to smoke ____ Quit date: _____

Current smoker ____ ___ packs/day for ___ years

Alcohol use___Y ___N # drinks/week:_____

Occupation: _____

Height: _____ Weight: _____