Boise Dermatology

3109 S. Meridian Rd., Meridian, ID 83642 (208) 888-0660

Medical History Form– *Please complete both sides*

Patient Name: _____ Birth date: _____

Occupation: _____

Reason for visit: **CIRCLE ALL THAT APPLY.**

Rash **Acne** **Moles** **Suspicious Lesion** **Skin check**

Preferred Pharmacy: _____ Preferred Pharmacy Phone: _____

Pharmacy Address: _____

A. Past Medical History: (Please circle all that apply.) NONE

Anxiety	Depression	
Arthritis	Diabetes	Ulcerative Colitis
Asthma	End Stage Renal Disease	Crohn's disease
Atrial fibrillation	GERD	HYPERthyroidism
Autoimmune disease	Hepatitis	HYPOthyroidism
COPD	High Blood pressure	Seizures
Coronary Artery Disease	HIV/AIDS	Stroke
Cancer--Type:_____	High Cholesterol	Transplant—Type:_____

Other major illnesses or recent hospitalization: _____

B. Past Surgical History: NONE

Procedure:_____ Date: _____

C. Skin Disease History: (Circle all that apply and indicate date and location.)

Condition	Date	Location	Condition	Date	Location
Actinic Keratoses			**Melanoma**		
Basal Cell Skin Cancer			**Psoriasis**		
Blistering Sunburns			**Squamous Cell Skin Cancer**		
Eczema			**NONE**		
Hay Fever/Allergies			**Other**		

D. Family Melanoma History:

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)_____

E. ENTER PRESCRIPTION MEDICATIONS OR PROVIDE A LIST ON A SEPARATE PAGE:

Medicine	Strength	Dosage	Frequency

F. ENTER ANY DRUG ALLERGY AND YOUR REACTION.

DRUG ALLERGY	REACTIONS

G. ALERTS: (Please check all that apply.)

Are you pregnant? ☐ **Yes** ☐ **No** Trying to become pregnant or breastfeeding? ☐ Yes ☐ No
Patients 65 or older- Have you received your pneumonia vaccine? ☐ Yes ☐ No
Do you use a tanning bed? ☐ Yes ☐ No
Do you use sunscreen? ☐ Yes ☐ No
Have you ever had difficulty healing or problems with bleeding? ☐ Yes ☐ No
Do you have a pacemaker or defibrillator? ☐ Yes ☐ No
Do you take any blood thinners or aspirin? ☐ Yes ☐ No
Have you ever had a rapid heartbeat with epinephrine? ☐ Yes ☐ No

Have you ever had a reaction or allergy to:

latex ☐ Yes ☐ No
lidocaine ☐ Yes ☐ No
tape ☐ Yes ☐ No
topical antibiotics ☐ Yes ☐ No

H. Social History: (Please circle all that apply)

Tobacco Use:
NONE
Currently Smokes:
_____ # packs per day
Has smoked in the past
Never smoked

Alcohol Use:
NONE
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

I. Other History: I am bothered by: (please check all that apply)

- ☐ Redness of my Face
- ☐ Fine lines & wrinkles on my face
- ☐ "Crow's feet"
- ☐ Smile Lines
- ☐ Frown Lines
- ☐ Forehead lines
- ☐ Angry 11's
- ☐ Thin lips
- ☐ Wrinkles around my mouth
- ☐ "Hollow" cheeks/cheek augmentation
- ☐ Red spots on my face/body
- ☐ Deep Lines on my cheeks/"jowls"
- ☐ Dark spots on my face/chest/hands
- ☐ Discoloration/Sunspots
- ☐ Wrinkles around eyes
- ☐ Preventative Skin Care
- ☐ Moles that I would like checked
- ☐ Sunscreen Product

Procedures or products of interest to you (please check all that apply)
- ☐ Botox & Dysport
- ☐ Restylane
- ☐ EltaMD
- ☐ Microneedling
- ☐ Blu Light