WACCAMAW DERMATOLOGY
Skin Cancer Institute

Phone: (843) 449-0453 Fax: (843) 449-9531
www.waccamawdermatology.com

Medical History Form

Last Name: _____ First Name: _____ DOB:_____
Height: _____ ft. _____ in. Weight: _____ lbs.
If you were referred to us, please list referring provider: _____
Why were you referred to us? _____
Internal Medicine/Family Doctor's Name: _____
Please list any drug allergies & your reaction:

_____

_____

Please list any medications (including blood thinners), supplements (including fish oil), infusions, etc you are currently taking:

_____

_____

_____

_____

History of skin cancer (please circle any that apply):
Basal Cell Squamous Cell Melanoma Other: _____
History of Skin Disorder: _____

Health History (please circle any that apply and use the lines below for anything else)
Heart Disease Stroke Rheumatic Fever Anemia Asthma HIV/AIDS Arthritis Diabetes
Glaucoma Tuberculosis Hepatitis Drug/Alcohol Dependency Bleeding Disorder Anxiety
Stomach Ulcer Kidney Disease Thyroid Disease Liver Disease Psychiatric Illness Cancer Pregnant

_____

_____

Please list previous surgeries, major illnesses, and hospitalizations:

_____

_____

Review of Systems (please circle any that apply):
Weight change Vision Skin Rash Breathing Difficulty Cough Chest Pain Diarrhea Dizziness
Easy Bleeding Swollen Ankles Tremor/Seizures Muscle Weakness Nausea Vomiting Constipation
Tiredness Fever Confusion Insomnia Skin Lesions Difficulty Urinating Loss of Taste Numbness

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Patient Name: _____

Social History (please circle any that apply):
Do you smoke: Yes No How many years: _____
Do you drink alcohol: Yes No How many alcoholic beverages per day: _____
Were you born in the South or lived here over 10 years: Yes No
Did you ever live on a farm: Yes No
Did you ever live on/near the beach: Yes No
Did you spend a lot of time doing outdoor activities (Swim/Fishing/Boating/Sun Bathing/Golf): Yes No
Did you have any blistering sunburns ever: Yes No
Do you have a family history of skin cancer: Yes No
Did you ever work outdoors: Yes No

Known Family Medical History (please list chronic or severe diseases as appropriate):
Mother: _____ Father: _____
Maternal Grandmother: _____ Maternal Grandfather: _____
Paternal Grandmother: _____ Paternal Grandfather: _____
Siblings: _____

Immunizations:
Flu: Yes No Date: _____
Pneumonia: Yes No Date: _____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I ALSO CERTIFY THAT I WILL REPORT CHANGES IN MY HEALTH HISTORY TO MY HEALTH CARE PROVIDER.

Signature: _____ Date: _____

FOR REPEAT VISITS, IF THERE ARE NO CHANGES TO YOUR HEALTH HISTORY SINCE YOU LAST COMPLETED THIS FORM, PLEASE SIGN AND DATE BELOW:

Signature: _____ Date: _____