DERMATOLOGY ASSOCIATES OF KENTUCKY, PSC
MEDICAL HISTORY FORM

Today's Date:	DAK Provider:

PATIENT INFORMATION

Last Name:	First:	Middle:	Birth Date: / /

Primary Language: ☐ English ☐ Arabic ☐ French ☐ German ☐ Mandarin ☐ Spanish ☐ Russian ☐ Other

Race: ☐ American Indian ☐ Asian ☐ African American or Black ☐ Native Hawaiian/Other Pacific ☐ White ☐ Unknown ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Primary Pharmacy:	**Address:**

Physician who requested that you see a dermatologist, if any:

Primary Care Doctor:

Please list the names of ALL other doctors you see (cardiologist, gynecologist, etc.):

Are you currently enrolled in Hospice? ☐ Yes ☐ No

YOUR PERSONAL HISTORY

Melanoma	Yes	No			
Other Skin Cancer (Basal and Squamous)	Yes	No	Abnormal Scars	Yes	No
Adhesive tape allergy	Yes	No	Arthritis	Yes	No
Anticoagulant treatment	Yes	No	Asthma	Yes	No
Artificial heart valves	Yes	No	Cancer, not skin	Yes	No
Artificial joint	Yes	No	Diabetes	Yes	No
Bacitracin allergy	Yes	No	Eczema	Yes	No
Bleeding disorders	Yes	No	GERD/Gastric reflux	Yes	No
CLL / Chronic leukemia	Yes	No	Hay fever	Yes	No
Defibrillator	Yes	No	Heart disease	Yes	No
Dementia / Alzheimer's	Yes	No	High Blood Pressure	Yes	No
Epilepsy (seizures)	Yes	No	High cholesterol	Yes	No
Epinephrine sensitivity	Yes	No	HSV / cold sore	Yes	No
Fainting / syncope	Yes	No	Kidney disease	Yes	No
Hepatitis	Yes	No	Lung disease	Yes	No
HIV positive	Yes	No	Lupus	Yes	No
Immunosuppressed	Yes	No	Multiple Sclerosis	Yes	No
Mitral valve prolapse	Yes	No	Parkinson's disease	Yes	No
MRSA	Yes	No	Poor wound healing	Yes	No
Organ transplant	Yes	No	Psoriasis	Yes	No
Pacemaker	Yes	No	Thyroid disease	Yes	No

FAMILY HISTORY

Do you have a family history of melanoma?	Yes No	Family member:
Do you have a family history of other skin cancer(s)?	Yes No	Family member:
Do you have a family history of asthma?	Yes No	Family member:
Do you have a family history of allergies?	Yes No	Family member:
Do you have a family history of eczema?	Yes No	Family member:
Do you have a family history of psoriasis?	Yes No	Family member:

SOCIAL HISTORY

Occupation:	
Do you use tobacco?	Yes No
Alcohol consumption?	None Socially Moderate Heavy
Do you use sunscreen?	None Daily Occasionally
Tanning bed use?	No use Current Previous

FOR WOMEN ONLY

Are you pregnant?	Yes No	Are you breastfeeding?	Yes No
Are you trying to get pregnant?	Yes No	Are you on birth control?	Yes No
Do you have irregular menstrual cycles?	Yes No		

CURRENT MEDICATIONS

May we electronically verify your medication history? ☐ Yes ☐ No

Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:

MEDICATION ALLERGIES

Do you have any medication allergies: ☐ Yes ☐ No

List allergies and type of reaction:

CURRENT SYMPTOMS

Fever	Yes	No	Shortness of breath	Yes	No	Swollen lymph nodes	Yes	No
Chills	Yes	No	Nausea / vomiting	Yes	No	Joint pain	Yes	No
Fatigue	Yes	No	Abdominal pain	Yes	No	Rash / itch	Yes	No
Unintentional weight loss	Yes	No	Diarrhea	Yes	No	Headache	Yes	No
Eye Irritation	Yes	No	Constipation	Yes	No	Anxiety	Yes	No
Chronic cough	Yes	No	Easy bruising	Yes	No	Depression	Yes	No
			Blood clots	Yes	No			