ALEXANDER MILLER, M.D.

Patient Medical History Form

Patient Name: Last_____First_____Middle Init____

Date of Birth:_____

Medications: List all prescribed and over-the-counter medications, including vitamins, supplements (attach list, if desired)

_____

_____

_____

Allergies: ☐ Check if none

To Medications: ☐ No ☐ Yes List:_____

_____

To Topical products (examples: lotions, creams, ointments, fragrances, gloves, tape) ☐ No ☐ Yes

List:_____

Reactions to anesthetic: ☐ No ☐ Yes List:_____

Your Current and Past Medical Problems History – Have you had the following:

☐ No ☐ Yes Skin cancer (☐ Melanoma; ☐ Basal cell carcinoma; ☐ Squamous cell carcinoma; ☐ Other_____)
☐ No ☐ Yes Abnormal (atypical) moles removed
☐ No ☐ Yes Skin infections If yes, MRSA? ☐ No ☐ Yes
☐ No ☐ Yes Hay fever allergies
☐ No ☐ Yes Eczema List type, if known:_____
☐ No ☐ Yes Psoriasis
☐ No ☐ Yes Lupus erythematosus

☐ No ☐ Yes Lung disease List:_____
☐ No ☐ Yes High blood pressure
☐ No ☐ Yes Heart disease
☐ Pacemaker ☐ Arrhythmia (irregular heartbeat)
☐ Heart surgery ☐ Cardiac stents ☐ Cardiac bypass
☐ No ☐ Yes Stomach or intestinal disease_____
☐ No ☐ Yes Hepatitis If yes, list type:_____
☐ No ☐ Yes Kidney disease List type, if known:_____
☐ No ☐ Yes Liver disease List type, if known:_____
☐ No ☐ Yes Arthritis If yes, list type:_____
☐ No ☐ Yes Diabetes If yes, list type:_____
☐ No ☐ Yes Thyroid disease If yes, list type:_____

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Name:_____

☐ No ☐ Yes Hepatitis
☐ No ☐ Yes Tuberculosis
☐ No ☐ Yes HIV infection
☐ No ☐ Yes Stroke
☐ No ☐ Yes Poor blood circulation (peripheral vascular disease)
☐ No ☐ Yes Clots in legs; thrombophlebitis
☐ No ☐ Yes Blood disorders
- ☐ Prolonged bleeding
- ☐ Anemia List type:_____
- ☐ Leukemia List type:_____

☐ No ☐ Yes Cancer, other than skin cancer:
List: _____

☐ No ☐ Yes Past radiation treatments
Other health problems:_____

Female Patients Only

☐ No ☐ Yes Pregnant
☐ No ☐ Yes Presently trying to become pregnant
☐ No ☐ Yes Nursing (breastfeeding)

Family History

☐ Unknown
☐ No ☐ Yes Skin cancer: ☐ Basal cell ☐ Squamous cell ☐ Melanoma ☐ Other
☐ No ☐ Yes Other skin diseases_____

Social Habits

☐ No ☐ Yes Tanning bed use; if yes, frequency:_____
☐ No ☐ Yes Tobacco use
- ☐ Use now ☐ Used in past only
- ☐ Smoking (packs per day)_____
- ☐ Chewing tobacco

☐ No ☐ Yes Drinking alcohol
☐ No ☐ Yes Other drugs

Form filled out by: ☐ Patient ☐ Parent ☐ Guardian ☐ Other:_____

Name of person filling out form:_____

Date:_____ Signature:_____