

# PATIENT HISTORY

## Sierra Skin Institute

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

1) Primary reason for today's appointment? \_\_\_\_\_  
 \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Have you received treatment for this problem before today? \_\_\_\_\_

If yes, please describe (including any non-prescription creams you have tried):  
 \_\_\_\_\_  
 \_\_\_\_\_

2) Do you have other skin problems you would like evaluated? \_\_\_\_\_  
 (Note: These problems may require a second appointment. If you want more than one problem treated visit, your insurance company may refuse payment.)

3) Please list current medications: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

4) Please list any allergies to medications: \_\_\_\_\_

5) Do you have or have you ever had any of the following:

|  |     |    |                              |     |    |
|--|-----|----|------------------------------|-----|----|
| Asthma/lung disease                    | Yes | No | Have you used a tanning bed? | Yes | No |
| Blood Clot                             | Yes | No | Heart disease                | Yes | No |
| Diabetes                               | Yes | No | High blood pressure          | Yes | No |
| Do you bleed easily?                   | Yes | No | Joints replaced              | Yes | No |
| Do you have a history of cold sores?   | Yes | No | Kidney Disease               | Yes | No |
| Genetic disease (inherited)            | Yes | No | Liver disease                | Yes | No |
| Have any blood relatives had melanoma? | Yes | No | Nervous Disease              | Yes | No |
| Have you ever had skin cancer?         | Yes | No | Raised scar                  | Yes | No |

6) Is there anything else about your medical history which may be important for the doctor to know?

\_\_\_\_\_

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