

Jon K. Stern, M.D. & Associates
MEDICAL HISTORY

Patient Name _____ Date _____
Last First Middle

Age ____ Sex M F Referred by Self/Friend Dr. _____

Reason for & Location of today's problem _____

How long has the problem been present? _____

Was there any previous treatment? Yes No When? _____ Type? _____

Was a biopsy done? No Yes Biopsy done by referring Dr. Other _____

ALLERGIES None List _____

MEDICATIONS None Aspirin, last taken _____ blood thinners, last taken _____

LIST ALL MEDICATIONS, Vitamins, & Herbal supplements _____

SYSTEM REVIEW: Check all that apply regarding your health and add any other important problems.

SKIN <input type="checkbox"/> abnormal scarring <input type="checkbox"/> poor healing <input type="checkbox"/> other skin disorders _____	KIDNEY <input type="checkbox"/> normal <input type="checkbox"/> dialysis <input type="checkbox"/> other kidney problems _____	CONSTITUTIONAL SYMPTOMS <input type="checkbox"/> none <input type="checkbox"/> weight loss <input type="checkbox"/> fever <input type="checkbox"/> other _____	EYES/EARS/NOSE/THROAT <input type="checkbox"/> normal <input type="checkbox"/> glaucoma <input type="checkbox"/> hearing aid <input type="checkbox"/> plastic surgery
RESPIRATORY <input type="checkbox"/> normal <input type="checkbox"/> asthma <input type="checkbox"/> emphysema <input type="checkbox"/> other lung problem(s) _____	GASTROINTESTINAL <input type="checkbox"/> normal <input type="checkbox"/> stomach ulcer <input type="checkbox"/> colitis <input type="checkbox"/> other GI problems _____	MUSCULOSKELETAL <input type="checkbox"/> normal <input type="checkbox"/> arthritis <input type="checkbox"/> artificial joint <input type="checkbox"/> other _____	NEUROLOGICAL <input type="checkbox"/> normal <input type="checkbox"/> stroke <input type="checkbox"/> seizures <input type="checkbox"/> other _____
HEMATOLOGIC/LYMPHATIC <input type="checkbox"/> normal <input type="checkbox"/> anemia <input type="checkbox"/> bleeding problems <input type="checkbox"/> enlarged lymph nodes <input type="checkbox"/> transfusion <input type="checkbox"/> pregnant	ENDOCRINE <input type="checkbox"/> normal <input type="checkbox"/> diabetes <input type="checkbox"/> thyroid <input type="checkbox"/> other _____	CARDIOVASCULAR <input type="checkbox"/> normal <input type="checkbox"/> chest pain <input type="checkbox"/> artificial heart valve <input type="checkbox"/> pacemaker <input type="checkbox"/> high blood pressure <input type="checkbox"/> mitral valve prolapse <input type="checkbox"/> heart attack (when?) _____ <input type="checkbox"/> other _____	INFECTIONS <input type="checkbox"/> none <input type="checkbox"/> hepatitis <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> tuberculosis (T.B.) <input type="checkbox"/> transplant <input type="checkbox"/> other _____

PAST HISTORY

Previous skin cancer none list: _____

Location and date _____

Major illnesses or surgeries none list: _____

FAMILY HISTORY

Skin cancer none melanoma basal cell squamous cell other, list: _____

SOCIAL HISTORY

Occupation _____ Marital status: S M D W

Spouse name _____ Previous sunlight exposure or sunburns: mild moderate extensive

Do you wear: dentures glasses contact lenses Smoker: no yes, packs/day _____ former

Alcohol: no yes # of drinks per week _____ Alcohol or drug problems/addictions: no describe _____