

To be filled out by patient

Follow-up Medical History

Appointment Date: _____

Patient Name: _____

Date of Birth: _____

Check here if you DO NOT want us to mail your biopsy results to you

Occupation: _____

Marital status: _____

Problem #1

Describe the problem:

How long have you had the problem:

Where on your body are you having the problem:

How severe is the problem:

Previous treatment(s) you've tried for the problem:

Did treatment(s) help:

Problem #2

Describe the problem:

How long have you had the problem:

Where on your body are you having the problem:

How severe is the problem:

Previous treatment(s) you've tried for the problem:

Did treatment(s) help:

Amount of sun exposure you've had in your life:

Mild Moderate Severe

Do you wear sunscreen regularly?

No Yes If yes, SPF: _____

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New Follow-up
 Patient seen in last 4 weeks

PROVIDER: _____

APPT. TIME: _____

CHECK IN: _____

ROOMED: _____

CHECK OUT: _____

- Aetna
- UnitedHealthcare
- Asuris Northwest Health
- Anthem Blue Cross Blue Shield
- Premera Blue Cross
- First Choice Health
- LifeWise
- AARP
- Regence
- Medicare
- Coventry / First Health
- Other: _____

Are you currently experiencing any of these?

Excessive bleeding:..... No Yes

Poor wound healing:..... No Yes

Sensitivity to sun:..... No Yes

Keloid scar formation:..... No Yes

Allergy to topical antibiotics:..... No Yes

Allergy to Band-Aids:..... No Yes

Easy bruising:..... No Yes

Hair problems:..... No Yes

Nail problems:..... No Yes

Sensitive skin:..... No Yes

Fever / chills:..... No Yes

Feeling fatigued:..... No Yes

Joint aches associated with

skin symptoms:..... No Yes

Trouble sleeping because

of skin problem:..... No Yes

History of weight loss

associated with skin problem:..... No Yes

Activity level restricted

because of skin problem:..... No Yes

Very worried and anxious

about skin problems:..... No Yes

Do you use tobacco of any kind?

No Yes If yes, what type: _____

Do you use alcohol on a regular basis?

No Yes If yes, amount: _____

Any change in medications since your last visit?

No Yes:

Please list your allergies below:

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REVIEWED: PROVIDER SIGNATURE _____ DATE: _____