Holmkvist MD. Dahl MD.
Accredited Dermatology Medical Clinic Inc.

PATIENT HEALTH RECORD

NAME OF PATIENT: LAST_____FIRST_____MIDDLE_____

DATE OF BIRTH_____

MEDICATIONS: (Include non-prescription medications, topical medications, supplements, and birth control)

_____

_____

_____

ALLERGIES:

Medications_____

_____

Topical medications/products (such as adhesive tape, antibiotic ointments, fragrance):_____

_____

Latex (Gloves) ☐ Yes ☐ No

REASON FOR TODAY'S VISIT:

_____

CURRENT AND PAST MEDICAL PROBLEMS:

Please elaborate on "Yes" answers in space provided or at end of section

☐ Yes ☐ No Skin cancer (☐ Basal cell carcinoma ☐ Squamous cell carcinoma ☐ Melanoma ☐ Unknown)

☐ Yes ☐ No Abnormal moles (atypical or dysplastic nevi)

☐ Yes ☐ No Skin disease (☐ Eczema ☐ Psoriasis ☐ Acne ☐ Other_____)

☐ Yes ☐ No Hayfever/allergies

☐ Yes ☐ No Lung disease (☐ Asthma ☐ Other _____)

☐ Yes ☐ No Heart disease

- ☐ Pacemaker
- ☐ Valve replaced/repaired
- ☐ Coronary artery disease/blockage in arteries
- ☐ Heart attack/myocardial infarction
- ☐ Valve disease/murmur
- ☐ Irregular heart beat/arrhythmia
- ☐ Cardiac surgery/procedures _____

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☐ Yes ☐ No High Blood Pressure/hypertension _____
☐ Yes ☐ No Stomach or bowel disease _____
☐ Yes ☐ No Liver disease _____
☐ Yes ☐ No Kidney disease _____
☐ Yes ☐ No Joint disease/arthritis_____
☐ Yes ☐ No Artificial joints/implants_____
☐ Yes ☐ No Diabetes_____
☐ Yes ☐ No Stroke _____
☐ Yes ☐ No Migraine headaches _____
☐ Yes ☐ No Blood disorders (☐ Bleeding disorder ☐ Blood clot ☐ Anemia ☐ Other_____)
☐ Yes ☐ No Infectious diseases (☐ Tuberculosis ☐ Hepatitis ☐ HIV ☐ Other _____)
☐ Yes ☐ No Psychiatric disorder _____
☐ Yes ☐ No Other_____
Additional information on past or current health problems_____

FEMALE PATIENTS:

☐ Yes ☐ No Pregnant
☐ Yes ☐ No Planning to become pregnant
☐ Yes ☐ No Breastfeeding

FAMILY HISTORY: Please elaborate on "Yes" answers at end of section

☐ Unknown/adopted (skip to next section)
☐ Yes ☐ No Skin Cancer (☐ Basal cell carcinoma/Squamous cell carcinoma ☐ Melanoma)
☐ Yes ☐ No Skin Diseases (☐ Eczema ☐ Psoriasis ☐ Acne ☐ Other _____)
Family members affected/details_____

SOCIAL & HEALTH HABITS:

Tobacco use ☐ Never ☐ Past ☐ Current (packs per day ____)
Sunscreen use ☐ Daily/almost always ☐ Sometimes/for specific activities ☐ Rarely ☐ Never
Alcohol use ☐ Never ☐ Rarely ☐ Average number of alcoholic beverages per day_____
Tanning bed use ☐ Never ☐ Past ☐ Current

SIGNATURE*_____DATE_____

Patient Name_____*Parent/Guardian/Other -- Relationship_____

*Parent/Guardian signature required for minors

For Physician Use/Reviewed by_____Date_____