King Dermatology
675 Hwy 62 East, Suite 1
Mountain Home, AR 72653

Date: _____ MEDICAL HISTORY

Name: _____ DOB___/___/_____

Pharmacy: _____Primary Care Physician: _____

Who were you referred by? _____

What is the primary reason for your visit today? _____

Occupation: _____

Skin History:

Have you ever been seen by a dermatologist? _____ If yes, can we obtain any needed records? _____

Have you ever had a mole removed? _____ If yes, was it "Normal"? _____

Have you ever had a skin cancer? _____ If yes, what kind and where? _____

Have you ever had a melanoma? _____ If yes, when and where? _____

Do you have any family history of melanoma? _____

Have you been diagnosed with any other skin issues? _____

Current Medical Problems (Circle all that apply)

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- Bone Marrow Transplant
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Hearing Loss
- Hepatitis
- High Blood Pressure
- HIV/AIDS
- High Cholesterol
- Thyroid Problems
- Leukemia
- Lymphoma
- Prostate Cancer
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- Other_____
  _____
  _____

Past Surgical History:

Surgery	Hospital	Date

Do you have current medication list with you today? _____

Current Medications:

Name	Dose/Frequency

Allergies:

Name	Type of Reaction

Do you use Tobacco of any type?	Yes	No
Do you drink alcohol?	Yes	No
Are you pregnant/nursing?	Yes	No
	Yes	No

Patient Signature _____ Date _____