# King Dermatology
# 2062 Hwy 62 W
# 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 |
|---|---|
| | |
| | |
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| | |
| | |

**Allergies:**

| Name | Type of Reaction |
|---|---|
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| | |
| | |
| | |

| | | |
|---|---|---|
| Do you use Tobacco of any type? | Yes | No |
| Do you drink alcohol? | Yes | No |
| Are you pregnant/nursing? | Yes | No |
| Are you on any form of Birth Control? | Yes | No |

Patient Signature _____ Date _____