Holmkvist MD. Dahl MD.
ACCREDITED DERMATOLOGY MEDICAL CLINIC INC.

PATIENT HEALTH RECORD

NAME
Last_____First_____Middle_____

DATE OF BIRTH _____

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

_____

_____

_____

_____

ALLERGIES (Include medications, topical products, latex and other things that you are allergic to)

_____

_____

_____

REASON FOR TODAY'S VISIT

_____

YOUR CURRENT AND PAST MEDICAL PROBLEMS

Please elaborate on "Yes" answers

☐ Yes ☐ No Skin cancer (☐ Basal cell carcinoma ☐ Squamous cell carcinoma ☐ Melanoma ☐ Unknown type)
☐ Yes ☐ No Biopsy proven atypical or dysplastic moles
☐ Yes ☐ No Skin disease (☐ Eczema ☐ Psoriasis ☐ Acne ☐ Other_____)
☐ Yes ☐ No Hayfever/allergies
☐ Yes ☐ No Lung disease ☐ Asthma ☐ Other _____
☐ Yes ☐ No Heart disease (include information on diagnoses, surgeries, devices)
_____
_____
☐ Yes ☐ No Hypertension
☐ Yes ☐ No Organ transplantation _____
☐ Yes ☐ No Stomach or bowel disease _____
☐ Yes ☐ No Liver disease _____
☐ Yes ☐ No Kidney disease _____
☐ Yes ☐ No Joint disease/arthritis_____
☐ Yes ☐ No Artificial joints_____
☐ Yes ☐ No Diabetes _____
☐ Yes ☐ No Stroke _____

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□ 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_____

_____

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 □ Unknown type)

□ 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 □ *Parent/Guardian/Other _____

Name/Relationship_____

*Parent/Guardian signature required for minors

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