Howard L. Sofen, M.D.

MEDICAL HISTORY

REFERRING DOCTOR:	PHONE NUMBER:	FAX NUMBER:

Do you have a pacemaker or defibrillator?	Yes ☐	Do you or have you ever used a tanning bed?	Yes ☐
Have you ever had a sunburn?	Yes ☐	Do you use sunscreen?	Yes ☐

Do you have a history of…?

Emphysema/COPD	Yes ☐	Fainting	Yes ☐	HIV / AIDS	Yes ☐
Asthma	Yes ☐	Hepatitis A, B, C	Yes ☐	Lupus	Yes ☐
Depression or Anxiety	Yes ☐	Stroke	Yes ☐	Convulsions, seizures, epilepsy	Yes ☐
Seasonal allergies / Hay fever	Yes ☐	Diabetes	Yes ☐	Cancer (Type:)	Yes ☐
High blood pressure	Yes ☐	Thyroid Disease	Yes ☐	Joint replacement	Yes ☐
Heart failure	Yes ☐	Kidney disease / failure	Yes ☐	History of blood transfusion	Yes ☐
Heart attack	Yes ☐	Arthritis	Yes ☐	Artificial heart valves or joints	Yes ☐
Mitral valve prolapse	Yes ☐	Liver disease	Yes ☐	NONE of these	Yes ☐

MEDICATIONS

CURRENT MEDICATIONS:	ALLERGIES TO MEDICATIONS:

Have you ever had a reaction to Novocaine, Lidocaine, bandages, latex, or topical antibiotics? **Please describe.**

DERMATOLOGICAL HISTORY

Do <u>YOU</u> have a history of…?		**Does your <u>FAMILY</u> have a history of…?**	
Melanoma	Yes ☐	Melanoma	Yes ☐
Atypical / Dysplastic Moles	Yes ☐	Atypical / Dysplastic Moles	Yes ☐
Squamous Cell Carcinoma	Yes ☐	Squamous Cell Carcinoma	Yes ☐
Basal Cell Carcinoma	Yes ☐	Basal Cell Carcinoma	Yes ☐
Actinic Keratoses	Yes ☐	Actinic Keratoses	Yes ☐
History of keloids / scarring	Yes ☐	History of keloids / scarring	Yes ☐
Psoriasis	Yes ☐	Psoriasis	Yes ☐
Eczema	Yes ☐	Eczema	Yes ☐
Hives	Yes ☐	Hives	Yes ☐
NONE of these	Yes ☐	NONE of these	Yes ☐

REVIEW OF SYSTEMS

Do you currently suffer from…?

Fevers / Chills	Yes ☐	Abdominal Pain	Yes ☐	PCOS	Yes ☐
Weight loss	Yes ☐	Diarrhea	Yes ☐	Easy bleeding / bruising	Yes ☐
Loss of appetite	Yes ☐	Vision Problems	Yes ☐	Shortness of breath	Yes ☐
Night sweats	Yes ☐	Irregular Periods	Yes ☐	Nausea / Vomiting	Yes ☐
Joint aches	Yes ☐	Oral/Patch contraceptives	Yes ☐	Chest pain	Yes ☐
Photosensitivity	Yes ☐	Pregnant	Yes ☐	Headaches / Migraines	Yes ☐
Cough	Yes ☐	Breastfeeding	Yes ☐	NONE of these	Yes ☐