

# RONALD C. KNIPE, M.D., P.A. DERMATOLOGY MEDICAL HISTORY

Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>MEDICATIONS</b> (Include OTC's & Aspirin)
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____

<b>ALLERGIES</b>
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

<b>SOCIAL HISTORY</b>	
Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Drinks/Day
Smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Packs/Day

<b>FEMALES</b>
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Due Date ____/____/____

<b>SKIN HISTORY</b>	
Have you ever had skin cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No Type _____
Has anyone in your family had skin cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No Type _____
Do you have problems with healing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you develop abnormal scars?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you bleed easily?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have sensitivity with <b>local</b> anesthesia?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Do you have now, or have you ever had diseases or conditions of:</b>			
High Triglycerides/High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer (If Yes, What type?) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke/T.I.A.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Significant Change in Energy	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Unintentional Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Irregular Heart Beat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bladder/Urinary/Prostate Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker or Defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gastrointestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema/Chronic Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yeast Infection with Antibiotics	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis or Joint Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsions, Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis (If yes; What type and has it been treated?) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Joints, Pins, Rods, etc (If Yes, List) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
List any other Diseases or Conditions: _____			
List any Surgical Procedures: _____			

Reason for today's visit: \_\_\_\_\_

What is your occupation? \_\_\_\_\_ Hobbies: \_\_\_\_\_

What do you like to be called? \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Reviewed By: \_\_\_\_\_  
*Patient Signature* \_\_\_\_\_ Ronald Knipe, M.D. Amy Wells, A.R.N.P.  
 Jennifer Blattner, A.R.N.P.