

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

Name: _____ Date of Birth ____/____/____ Today's Date ____/____/____

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

ALLERGIES
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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

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

SKIN HISTORY	
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 local anesthesia?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have now, or have you ever had diseases or conditions of:			
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 C. Knipe, M.D. Amy Wells, A.P.R.N.
 Samantha A. Marrone, M.D. Jennifer Blattner, A.P.R.N.