110 Southern Oak Drive • Plant City, FL 33563
www.claytonderm.com • 813.752.0757

Medical History Form

Name: _____ DOB: _____

Medical History: (Circle all that apply)

Anxiety	Depression	Hyper/Hypothyroidism
Arthritis	Diabetes	Leukemia
Asthma	Enlarged Prostate	Lung Cancer
Atrial Fibrillation	GERD	Lymphoma
Bone Marrow Transplant	Hearing Loss	Prostate Cancer
Breast Cancer	Hepatitis B or C	Radiation Treatment
Colon Cancer	Hypertension	Renal Disease (End Stage)
COPD	High Cholesterol	Seizures
Coronary Artery Disease	HIV/AIDS	Stroke

Surgical History:

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Skin History: (Circle all that apply)

Acne	Eczema	Precancerous Moles
Actinic Keratosis	Flaking or Itchy Scalp	Psoriasis
Basal Cell Carcinoma	Hay Fever/Allergies	Squamous Cell Carcinoma
Blistering Sunburn	Melanoma	Other: _____
Dry Skin	Poison Ivy	

Use of: **Tanning Beds/Salon:** ☐ Yes ☐ No **Sunscreen:** ☐ Yes ☐ No

Family History:

Is there a family history of Melanoma? ☐ Yes ☐ No Relative: _____

Allergies:

None ☐ List all medication allergies: _____

_____

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Occupation:

Review of Systems: (Circle all that apply)

Artificial Heart Valve
Artificial Joints within the Past 2 Years
Allergy to Adhesive
Allergy to Topical Antibiotic Ointment
Antibiotics Prior to Procedures
Blood Thinners
Problems with Healing
Problems with Scarring (Hypertrophic or Keloid)
Rash
Transplant History

Alerts: (Circle all that apply)

Lidocaine Allergy
Pace Maker / Defibrillator
Latex Allergy
Rapid Heartbeat with Epinephrine
Pregnancy / Nursing

Nicotine Use: ☐ Former Smoker ☐ Current Smoker ☐ Never Smoked

Alcohol Use: ☐ Less than 1/Day ☐ 1-2 Drinks/Day ☐ 3 or More/Day