GOLDEN
DERMATOLOGY

2226 Liliha Street, Suite 302, Honolulu, HI 96817

Medical History Form

Name: _____ **Date of Birth:** _____

Phone number: _____ **Referring Physician:**_____

Primary Care Physician: _____ **Preferred Pharmacy:** _____

Reason for Visit: _____

Allergies

Allergic to latex?	☐ **Yes**	☐ **No**
Allergic to tape or adhesives?	☐ **Yes**	☐ **No**
Allergic to anesthetic or lidocaine?	☐ **Yes**	☐ **No**

List ALL allergies to medications:	**Reaction:**

Do you take antibiotics before dental procedures?	☐ **Yes**	☐ **No**
Do you have a joint replacement?	☐ **Yes**	☐ **No**
Do you have a pacemaker or defibrillator?	☐ **Yes**	☐ **No**
Do you have a history of a transplant?	☐ **Yes**	☐ **No**

Do you smoke? ☐ **Yes** _____ **packs per day** ☐ **No** ☐ **Former Smoker**

Do you drink alcohol? ☐ **Yes** _____ **drinks per week** ☐ **No**

Occupation: _____

Are you on the following? (Please circle)

Blood thinners:
Coumadin/warfarin, Heparin, Plavix/clopidogrel, Pradaxa/dabigatran, Xarelto/rivaroxaban
Aspirin
Anti - Inflammatories (NSAIDS, ibuprofen)
Vitamin E
Fish Oil

Are you <u>CURRENTLY</u> having any of the following symptoms (please circle):

Fever **Chills** **Weight loss** **Loss of Appetite** **Night Sweats** **Swollen Lymph nodes**

Past Medical History and Review of Symptoms:
Please check ALL of the following that you currently have or have had in the past.

Skin History:

- ☐ Basal cell carcinoma
- ☐ Squamous cell carcinoma
- ☐ Melanoma
- ☐ Pre-cancer (Actinic Keratosis)
- ☐ Atypical/Dysplastic Moles
- ☐ Abnormal Scars/Keloids
- ☐ Tanning bed use
- ☐ Blistering sunburns
- ☐ History of Rashes
- ☐ Family history of skin cancer

Cardiovascular

- ☐ Heart Attack / Chest pain
- ☐ Valve Problem / Murmur
- ☐ Prosthetic valve / Pacemaker
- ☐ High blood pressure
- ☐ Irregular heart rhythm
- ☐ Peripheral vascular disease

Respiratory

- ☐ COPD / Emphysema
- ☐ Asthma
- ☐ Oxygen Use: _____Liters
- ☐ Cough

Neurological

- ☐ Seizure / Epilepsy
- ☐ Stroke / Paralysis
- ☐ Nerve Pain / Neuralgia
- ☐ Numbness / Tingling

Endocrine

- ☐ Diabetes
- ☐ Thyroid

Musculoskeletal

- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Artificial Joints:

Which Joint: _____
Date: _____

Gastrointestinal

- ☐ Hepatitis
- ☐ Liver Disease / Jaundice
- ☐ Stomach Ulcers

Genitourinary

- ☐ Dialysis
- ☐ Kidney Disease
- ☐ Genital problems

Autoimmune

- ☐ Lupus
- ☐ Rheumatoid arthritis
- ☐ Other: _____

Infections

- ☐ HIV / AIDS
- ☐ Tuberculosis
- ☐ Hepatitis B or C

Ear/Nose/Throat

- ☐ Cataracts / Glaucoma
- ☐ Hearing Aids
- ☐ Other: _____

Psychiatric

- ☐ Depression / Anxiety
- ☐ Dementia
- ☐ Other: _____

Transplants:

Location:_____
_____
Date: _____

Medical Problems
Problems not addressed above:_____

Major Surgeries: _____

List All Medications and Doses: (Attach additional sheet if necessary)

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Patient Signature: _____**Date:**_____