

I. PAUL RAPPAPORT, M.D.
PATIENT MEDICAL HISTORY FORM

(Requires update every 2 years)

Last Name _____ First Name _____ Middle _____

Date of Birth _____ Occupation _____ Primary Physician: _____

Did your primary doctor refer you to us? Y__N__

Primary reason for appointment(list single problem here): _____

How long have you had this problem? _____ Have you received treatment? Y__N__

If so, please describe _____

Do you have other skin problems you would like evaluated? _____

Please list all current medications _____

Please list any allergies _____

Are you allergic or sensitive to: Y__N__ Novocaine Y__N__ Lidocaine

Are you allergic to Latex? Y__N__

Do you take antibiotics for dental procedures? Y__N__ If yes, please list _____

Are currently on Aspirin Y__N__ Coumadin Y__N__ Plavix Y__N__ or any other blood thinner Y__N__

If yes, _____

SURGICAL HISTORY:

Y__N__ Mohs Surgery Y__N__ Coronary Bypass Y__N__ Artificial Heart Valve

Y__N__ Artificial joint Y__N__ Implanted Defibrillator Y__N__ Pacemaker

Have you ever had skin surgery? Y__N__ If yes, type _____

Have you ever had cosmetic surgery? Y__N__ . If yes, type _____

Have you had any other surgery in the past 5 years? Y__N__ . Please describe _____

HAVE YOU HAD ANY OF THE FOLLOWING:)If yes, explain where necessary)

Y__N__ Skin Cancer If yes, _____ Y__N__ Stroke/TIA If yes, _____

Y__N__ Lung Disease If yes, _____ Y__N__ Other Cancer If yes, _____

Y__N__ Blood Clot If yes, _____ Y__N__ Eye Problems If yes, _____

Y__N__ Arthritis If yes, _____ Y__N__ Seizure Disorder If yes, _____

Y__N__ Ear Problems If yes, _____ Y__N__ Melanoma If yes, _____

Y__N__ Nervous Disease If yes, _____ Y__N__ Anemia If yes, _____

Y__N__ Heart Attack If yes, _____ Y__N__ Dizziness/Fainting If yes, _____

Y__N__ Bleed Easily If yes, _____ Y__N__ Heart Surgery If yes, _____

Y__N__ Diabetes If yes, _____ Y__N__ Tuberculosis If yes, _____

Y__N__ High Blood Pressure If yes, _____ Y__N__ Thyroid Trouble If yes, _____

Y__N__ Hepatitis Virus If yes, _____ Y__N__ Mitral Valve Prolapse If yes, _____

Y__N__ Kidney Trouble If yes, _____ Y__N__ Genetic Disease If yes, _____

Y__N__ Actinic Keratosis If yes, _____ Y__N__ Liver Disorder If yes, _____

Y__N__ Sinus Trouble If yes, _____ Y__N__ Hair Problems If yes, _____

Y__N__ Biopsied Abnormal Moles If yes, _____ Y__N__ Asthma If yes, _____

Y__N__ Palpitations If yes, _____ Y__N__ Headaches If yes, _____

Y__N__ Hay Fever If yes, _____ Y__N__ Oral Sores If yes, _____

Y__N__ Eczema If yes, _____ Y__N__ Exposure to HIV/AIDS If yes, _____

Y__N__ Radiation Treatment If yes, _____ Y__N__ Psoriasis If yes, _____

Y__N__ Keloid Scars If yes, _____ Y__N__ Problems with healing If yes, _____

SOCIAL HISTORY:

Do you drink alcohol? Y__N__ Frequency: daily Social Quantity Occasionally

Do you use any illicit drugs? Y__N__ If so, what type? _____

Do you smoke? Y__N__ Do you live in a smoke-free home? YN

Do you consume caffeine? Y__N__ If yes, Coffee Soda Tea Chocolate

Do you consume: Daily__ Occasionally__

Do you use sunscreen? Daily__ When outside for any length of time__ Often__ Sometimes__ Never__

Type of sunscreen: SPF15__ SPF30 or greater__ Brand Name _____

Have you ever had blistering sunburns? Y__N__

