THE BOWMAN INSTITUTE
FOR DERMATOLOGIC SURGERY

MEDICAL HISTORY FORM

Please complete this form in its entirety. It will help us give you the best medical care possible, and will not be shared with anyone without your consent.

Date: ____/_____/_____

Patient Name: _____

Date of Birth: ____/_____/_____

Please list the lesions to be evaluated/treated:

Lesion #1: Location: _____

Lesion #2: Location: _____

Lesion #3: Location: _____

Other concerns:

5379 Primrose Lake Circle, Tampa, FL 33647
(813) 977 - 2040 • Fax (813) 977 - 3886
TheBowmanInstitute.com

MEDICAL INFORMATION

Height_____ Weight_____

Please list your daily medications, vitamins and any herbal supplements:

☐ *I am **not** taking any medications, vitamins or supplements*

Medication Name	Dose	Route (by mouth, etc.)	Frequency (once a day…)

Please list any allergies and your reaction

☐ *I have **no** allergies*

Agent	Describe Reaction

Please list any chronic condition(s), hospitalizations and surgeries:

☐ *I do **not** have any conditions, hospitalizations or surgeries to report*

Condition, hospitalization or surgery	Date

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Do you have:

☐ **Yes** ☐ **No** Any artificial joints? If yes, date most recent one placed? _____

☐ **Yes** ☐ **No** A prosthetic heart valve? If yes, date placed? _____

☐ **Yes** ☐ **No** Any cardiac stent(s)? If yes, date placed? _____

☐ **Yes** ☐ **No** A pacemaker? If yes, date placed? _____

☐ **Yes** ☐ **No** A cardiac defibrillator? If yes, date placed? _____

☐ **Yes** ☐ **No** A splenectomy (your spleen has been removed) If yes, date?

Have you ever had:

☐ **Yes** ☐ **No** Hepatitis (inflammation of the liver) If yes, what type? _____

☐ **Yes** ☐ **No** HIV or AIDS? If yes, CD4 count_____ Viral Load_____

REVIEW OF SYSTEMS

Do you have problems with any of the following:

☐ **Yes** ☐ **No** Fever, Shaking, Chills

☐ **Yes** ☐ **No** Weight Loss

☐ **Yes** ☐ **No** Night sweats

☐ **Yes** ☐ **No** Cold Sores

☐ **Yes** ☐ **No** Hearing

☐ **Yes** ☐ **No** Difficulty with tearing

☐ **Yes** ☐ **No** Heart murmur

☐ **Yes** ☐ **No** Difficulty breathing

☐ **Yes** ☐ **No** Frequent urination

☐ **Yes** ☐ **No** Weakness

☐ **Yes** ☐ **No** Diabetes

☐ **Yes** ☐ **No** Dizziness

☐ **Yes** ☐ **No** Falls

☐ **Yes** ☐ **No** Frequent infections

☐ **Yes** ☐ **No** Swollen lymph nodes

☐ **Yes** ☐ **No** History of precancers, other active skin conditions

Have you had the

Flu Shot ☐ Y ☐ N approx. date _____

Pneumonia vaccine ☐ Y ☐ N approx. date _____

SKIN CANCER HISTORY

☐ **Yes** ☐ **No** Have you had non-melanoma skin cancer?

☐ **Yes** ☐ **No** Have you had a melanoma?

☐ **Yes** ☐ **No** Do you have any *first degree relatives* that have had melanoma?

If yes, complete the following:

☐ My Father has had melanoma	☐ Alive ☐ Deceased
☐ My Mother has had melanoma	☐ Alive ☐ Deceased
☐ My Sibling has had melanoma	☐ Alive ☐ Deceased
☐ My Child has had melanoma	☐ Alive ☐ Deceased

SOCIAL HISTORY

Do you smoke? ☐ **Yes** ☐ **No**

If *yes*, how much? ____ packs per day

Do you drink alcohol? ☐ **Yes** ☐ **No**

If yes: How often? ☐ Monthly/Occasionally ☐ 2 to 4x/Month ☐ 2 to 3x/Week ☐ 4 or more x/week

How many drinks each time? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7+

How often do you have 6+ drinks on one occasion? ☐ Never ☐ Monthly ☐ Weekly

Do you have a history of *alcohol abuse*? ☐ **Yes** ☐ **No**

If *yes*, please explain: _____

Do you have a history of *drug abuse*? ☐ **Yes** ☐ **No**

If *yes*, please explain: _____

Do you drive? If *yes*, do you drive at night? ☐ **Yes** ☐ **No**

With whom do you live? ☐ **Spouse** ☐ **Child** ☐ **Alone** ☐ **Other**: _____

Occupation: ☐ **Current** ☐ **Former**

_____

Thank you for taking the time to provide this important information that will assist us in providing your care!

Please sign here:

Date completed

Patient (or person completing form and Relationship to patient)

By signing above, I certify that all of the information on this medical history form is true and correct to the best of my knowledge.

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