Updegraff Clinic for Allergy and Dermatology

PATIENT MEDICAL HISTORY

(Please Print)

Patient Name: _____ Date: _____

PATIENT PRIMARY CARE PROVIDER & PHARMACY PREFERENCE INFORMATION

Primary Doctor: _____ Phone No.: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Pharmacy: _____ Phone No.: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Length of Arizona Residency _____ Years _____ Months Do you Smoke? ☐ Yes ☐ No If Yes, for how long? _____

Frequency of Alcohol Consumption: _____

Have you ever been diagnosed with skin cancer? ☐ Yes ☐ No

If yes, what kind? ☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma ☐ Melanoma

Family History of Skin Cancer? ☐ Yes ☐ No If yes, what family member and what kind of cancer did they have?

_____

Do you have a history of (check all that apply): ☐ Blistering sunburn ☐ Tanning bed use ☐ Radiation or X-Ray treatments

MEDICAL HISTORY

Check all conditions that you have ever had or have at the present time

☐ Allergies / Hay Fever	☐ Chronic Cough	☐ High Blood Pressure	☐ Pacemaker
☐ Anxiety	☐ Depression	☐ HIV / AIDS	☐ Post Nasal Drip
☐ Arthritis	☐ Diabetes	☐ Hives	☐ Psoriasis
☐ Asthma	☐ Eczema	☐ Infections (frequent)	☐ Runny Nose
☐ Autoimmune Disease	☐ Emphysema / COPD	☐ Itchy / Burning Eyes	☐ Shingles
☐ Bleeding Tendency	☐ Faint Easily	☐ Keloids	☐ Sinusitis
☐ Bronchitis (chronic)	☐ Headaches	☐ Liver Disease	☐ Stroke
☐ Cancer (not skin)	☐ Heart Attack / Failure	☐ Lupus	☐ Thyroid Disease
☐ Chest Pain	☐ Hepatitis Type	☐ Migraines	

☐ Other medical Conditions Not Listed Above: _____

_____

IN CASE OF EMERGENCY

Name of local friend or relative: _____

Relationship to patient: _____ Phone No.: _____

Authorization to give confidential information to emergency contact? ☐ Yes ☐ No

The above information is true to the best of my knowledge.

Patient / Guardian Signature _____ Date _____