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MEDICAL HISTORY FORM

Welcome to the office of Dr. Esche! Our care requires a broad understanding of your past and present health. Please complete the following questionnaire.

PLEASE PRINT OR TYPE IN BLUE OR BLACK INK

Thank you!

First Name: _____ Last Name: _____
Social Security Number _____ Marital Status: _____
Date of Birth: _____ Gender: Male Female
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email Address: _____
Free Email Newsletter Subscription: Yes No

Do we have permission to:

Leave a message on your answering machine at home? Yes No

Leave a message at your place of employment? Yes No

Discuss your medical condition with any member of your household Yes No

If yes, whom: _____ Relationship: _____

Occupation / School: _____

Hobbies? _____

Referring Physician: _____ Phone: _____

Address: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Pharmacy: _____ Phone: _____

Reason for your visit today (1):

Location: face neck trunk extremities hands feet
Duration: days weeks months unsure
Severity: mild moderate severe
Symptoms: itchy painful growing color change bleeds
Improved by: _____ Made worse by: _____
Prior treatment: _____ Response: _____
Current Care: _____

Reason for your visit today (2):

Location: face neck trunk extremities hands feet
Duration: days weeks months unsure
Severity: mild moderate severe
Symptoms: itchy painful growing color change bleeds
Improved by: _____ Made worse by: _____
Prior treatment: _____ Response: _____
Current Care: _____

Reason for your visit today (3):

Location: face neck trunk extremities hands feet
Duration: days weeks months unsure
Severity: mild moderate severe
Symptoms: itchy painful growing color change bleeds
Improved by: _____ Made worse by: _____
Prior treatment: _____ Response: _____
Current Care: _____

Reason for your visit today (4):

Location: face neck trunk extremities hands feet
Duration: days weeks months unsure
Severity: mild moderate severe
Symptoms: itchy painful growing color change bleeds
Improved by: _____ Made worse by: _____
Prior treatment: _____ Response: _____
Current Care: _____

Skin Related Review of Systems (Current or past problems):

- Acne: Yes No
Eczema (atopic dermatitis): Yes No
Psoriasis: Yes No
Dry skin: Yes No
Oily skin: Yes No
Cold sores / herpes infections: Yes No
Keloids / abnormal scarring: Yes No

Abnormal cold sensitivity: Yes No
Abnormal sun sensitivity: Yes No
Do you spend long hours in the sun? Yes No
Have you ever had a blistering sunburn? Yes No

If first exposed to the sun in the summer without sunscreen, would you

- always burn, never tan always burn, sometimes tan
 sometimes burn, always tan gradually burn minimally, always tan well
 rarely burn, tan profusely never burn, deeply pigmented

Tanning bed use: never occasionally weekly

- Abnormal (dysplastic) moles: Yes No
If yes, what year: _____
Skin cancer - Melanoma: Yes No
If yes, what year: _____
Skin cancer - Basal cell: Yes No
If yes, what year: _____
Skin cancer - Squamous cell: Yes No
If yes, what year: _____
Precancerous spots (AKs): Yes No
If yes, what year: _____
Liquid nitrogen for precancers: Yes No
If yes, what year: _____
Aldara used for precancers: Yes No
If yes, what year: _____
Efudex used for precancers: Yes No
If yes, what year: _____

Current Health:

Do you smoke? Yes No If yes, number of packs per day? _____
Do you drink? Yes No If yes, how many drinks a day? _____
Do you use drugs? Yes No If yes, which drugs? _____

Medical History / Other Review of Systems

Asthma: Yes No
Bowel Disease: Yes No
Diabetes / high blood sugar: Yes No
Recent fever: Yes No
Fainting: Yes No
Glaucoma: Yes No
Hay fever / seasonal allergies: Yes No
Headache: Yes No
Heart attack / angina: Yes No
Heart murmur: Yes No
High blood pressure: Yes No
HIV or AIDS: Yes No
Joint pain: Yes No
Kidney / bladder problems: Yes No
Liver disease or hepatitis: Yes No
Lung disease: Yes No
Lupus: Yes No
Pacemaker / defibrillator: Yes No
Psychological disorders: Yes No
Seizures: Yes No
Thyroid disease: Yes No
Recent weight gain: Yes No

Current Health:

If yes, how many lbs _____ in how many months: _____
Recent weight loss: Yes No
If yes, how many lbs: _____ in how many months: _____

Family History:

Asthma: Yes No
Hay Fever / seasonal allergies: Yes No
Abnormal (dysplastic) moles: Yes No
Skin Cancer - Melanoma: Yes No
Skin Cancer - Basal cell: Yes No
Skin Cancer - Squamous cell: Yes No

Medications:

Aspirin / Motrin / Advil

Yes No

Coumadin / Plavix

Yes No

List all other medications you are taking, including any over-the-counter herbals or vitamins: _____

Allergies:

Do you have any medication allergies?

Yes No

If yes, please list: _____

Reaction to local anesthetic:

Yes No

If yes, please list: _____

Do you have other allergies?

Yes No

If yes, please list: _____

For Females Only:

Birth control pills:

Yes No

Are you breastfeeding:

Yes No

Are you pregnant:

Yes No

Plan on becoming pregnant:

Yes No

Regular menstrual periods:

Yes No

Recurrent yeast infections:

Yes No

I certify that the information that I have provided is correct. (Must be signed by patient if over 18 or by legal guardian of patient under 18.)

Signature of patient (or legal guardian)

Date

To be completed by Dr. Esche:

I certify that I have reviewed and discussed the above information with the patient and have added any additional findings below: _____

Dr. Clemens Esche

Date

To be completed by receptionist: Co-pay paid today: \$ _____