Patient Name: _____ **DOB:** _____

Past Medical History: (Please Circle/Check all that apply)

None
Anxiety Disorder
Arthritis
Asthma
Atrial Fibrillation
Benign Prostatic Hyperplasia
Cerebrovascular Hyperplasia
Chronic Obstructive Lung Disease
Coronary Arteriosclerosis
Depressive Disorder
Diabetes Mellitus
Disease caused by 2019-nCov
Elevated Blood Pressure
End Stage Renal Disease
Epilepsy
Gastroesophageal Reflux Disease
Hearing Loss
History of Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Inflammatory Disease of Liver
Leukemia
Malignant Lymphoma (Clinical)
Malignant Tumor of Breast
Malignant Tumor of Colon
Malignant Tumor of Lung
Malignant Tumor of Prostate
Radiation Therapy
Transplantation of Bone Marrow
Other: _____

Past Surgeries: (Please list)

_____

Skin Disease History: (Please Circle/Check all that apply)

None
Acne
Actinic Keratosis
Basal Cell Carcinoma of Skin
Dysplastic Nevus of Skin
Eczema
History of Asthma
History of Hay Fever
Malignant Melanoma
Psoriasis
Squamous Cell Carcinoma
Other: _____

Do you regularly Wear Sunscreen? YES SPF_____ NO
Do you tan in a tanning salon? YES NO
Do you have a family history of Melanoma YES NO

If yes, Which Relatives: _____

Cigarette Smoking:

Current Every Day
Current Some Day Smoker
Former Smoker
Former Smoker
Never Smoked

Occupation: _____

450 NW Gilman Blvd Suite 301A/B, Issaquah, WA 98027
T: 425-654-1275 • F: 425-654-0539 • www.millerfamilydermatology.com

Please CLEARLY print all current medications OR give us a list that we can copy

_____

_____

_____

_____

_____

_____

Allergies to Medications:

_____

_____

_____

_____

_____

Coordination of Care:

Preferred Pharmacy Name & Location:

_____

Name of your primary care or family doctor (PCP/GP) & Office Location:

_____