

Patient Name: _____

Date of Birth: _____

DERMATOLOGY HEALTH HISTORY

Skin Cancer History	
Have you ever had Basal cell carcinoma or Squamous cell carcinoma: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, when was your most recent one diagnosed or biopsied?: _____
Have you ever had melanoma in situ?: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, where on your body?: _____ and when? _____
Have you ever had melanoma?: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, where on your body?: _____ and when? _____
Have you ever had any other type of skin cancer?: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, what type?: _____ and when? _____
When was your last full body skin check: _____	

Family History			
Yes	No	Condition	Family Member(s)
<input type="checkbox"/>	<input type="checkbox"/>	Alopecia Areata	
<input type="checkbox"/>	<input type="checkbox"/>	Basal cell carcinoma	
<input type="checkbox"/>	<input type="checkbox"/>	Eczema	
<input type="checkbox"/>	<input type="checkbox"/>	Lupus	
<input type="checkbox"/>	<input type="checkbox"/>	Melanoma	
<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	
<input type="checkbox"/>	<input type="checkbox"/>	Squamous cell carcinoma	
<input type="checkbox"/>	<input type="checkbox"/>	Vasculitis	
<input type="checkbox"/>	<input type="checkbox"/>	Vitiligo	
<input type="checkbox"/>	<input type="checkbox"/>	Other	

Patient Signature (or caregiver/ parent/guardian if minor)

Date

If signed by the Patient's Representative, please print name and describe relationship to patient or other authority to act:

Name

Relationship to Patient