**Dr. Clemens Esche**
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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: __________________
What would you like to be called? ________________________
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: __________________

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**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

Sunscreen use: ☐ never ☐ occasionally ☐ daily ☐ SPF 1-15 ☐ SPF 15+
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: __________

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**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 murmer: ☐ 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
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 menstral 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