Dermatology Partners of WNY, LLP
Clinical History Form

Patient's Name:_____ **Date:**_____

D.O.B._____

Pertinent Medical History:_____
_____
_____

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other Family History:_____

Medications: (Please enter all current medications) **Please Circle Here if None:** – No Medications

Allergies: (Please enter all allergies) P**lease Circle Here if None:** – No Allergies
_____
_____

Pregnant or Breastfeeding: Yes No N/A

Cigarette Smoking: Please Circle
Never smoked/Not Applicable (child)
Quit: former smoker
Smokes less than daily
Smokes daily

Primary Spoken Language: Please Circle
English
Spanish
Other:_____

Pharmacy: Name_____

Street/City:_____Zipcode:_____

Phone:_____

Last Updated:02/28/2018