CRANE STREET DERMATOLOGY
1225 Crane Street, Suite 102 · Menlo Park, CA 94025

MEDICAL HISTORY

Name:_____ Date Of Birth:____/____/____/

Pharmacy:_____ Location:_____

Primary Care Physician:_____ Location:_____

Preferred Language:_____Race:_____

Ethnic Group: Not Hispanic/Latino:_____ Hispanic/Latino:_____ Unknown:_____

Past Medical History: (Please Circle All That Apply)

Anxiety	Diabetes	Hypothyroidism
Arthritis	End Stage Renal Disease	Leukemia
Atrial Fibrillation(Irregular Heartbeat)	Epilepsy	Lung Cancer
Bone Marrow Transplantation	Gerd	Malignant Lymphoma
Benign Prostatic Hyperplasia	Hearing Loss	Migraine
Breast Cancer	Hepatitis	Prostate Cancer
Colon Cancer	High Blood Pressure	Radiation Treatment
Copd	High Cholesterol	Seizure Treatment
Coronary Artery Disease	HIV/AIDS	Seizure Disorder
Depression	Hyperthyroidism	None
Disease Caused By 2019-Covid		

Other:_____

Past Surgical History: (Please Circle All That Apply)

Adenoidectomy	Kidney: Transplant/Biopsy/Removal-Right, Left
Appendix Removed	Knee Replacement (Right, Left, Both)
Bladder Removed	Kidney Stone Removal
Breast: Lumpectomy(Right, Left, Both)	Liver: Transplant/Shunt
Breast:Mastectomy(Right, Left, Both)	Ovaries: Endometriosis/Cyst/Cancer
Breast: Biopsy (Right, Left, Both)	Pancreatectomy
Colon: Complete Removal, Partial Removal	Prostate: Biopsy/Cancer/Turp/Removal
Cholecystectomy: Gallbladder Removal	Skin Biopsy
Excision: Basal Cell, Squamous Cell, Melanoma	Spleen Removed
Heart Transplant	Testicles Removed (Right, Left, Both)
Heart: Mechanical Or Biological Valve Replacement	Tonsillectomy
Hip: Joint Replacement (Right, Left, Both) Tubal Ligation	Wisdom Tooth Excision
Hysterectomy: Fibroids/Cervical Cancer/Uterine Cancer	None

Other:_____

Info@CraneStreetDermatology.com
Phone: (650) 323-0276 · Fax: (650) 323-8540

MEDICAL HISTORY

Skin Disease History: (Please Circle All That Apply)

Acne	Eczema	Melanoma
Actinic Keratoses	Flaking Or Itchy Scalp	Precancerous Moles
Asthma	Hay Fever/Allergies	Problems With Healing
Basal Cell Skin Cancer	Hypertrophic Scar	Psoriasis
Blistering Sunburns	Keloid	Squamous Cell Skin Cancer
Dry Skin	Poison Oak	None

Other:_____

Do You Wear Sunscreen? Yes No Do You Tan In A Tanning Salon? Yes No
If Yes, What SPF?_____

Do You Have A Family History Of Melanoma? Yes No If Yes Which Relative(S)?_____

Medications: Please Enter All Current Medications)
_____
_____

If Patient Between Ages Of 0-21 Years:
Height: Weight:

Allergies: (Please Enter All Allergies)
_____
_____

Social History: (Please Circle All That Apply)

Cigarette Smoking:
- Currently Smokes
- Has Smoked In The Past
- Dates- From____to_____
- Never Smoked

Alcohol Use:
- None
- Less Than 1 Drink Per Day
- 1-2 Drinks Per Day
- 3 Or More Drinks Per Day

Family History Of Skin Conditions (Immediate Family)
_____
_____

Do You Have Any Of The Following Immunizations?:
Covid Vaccine #1___yes____no
Covid Vaccine #2___yes____no
Covid Vaccine (Booster)____yes____no

Influenza Immunization _____yes _____no Year Completed_____
Pneumonia Immunization____yes_____no Year Completed_____

Do You Have An Advance Care Directive?: YES NO
Who Is The Person To Make Decisions For You?_____
Phone #:_____