Dermatology Medical History

Patient: _____Date of Birth:____/____/____ Age: ___ Today's Date:____/____/____

Reason for today's visit: _____

Are you allergic to any medications? ❑ YES ❑ NO If yes, list below:

_____

Have you ever had local anesthesia (Dentist or Doctor)? ❑ YES ❑ NO Any bad reaction? ❑ YES ❑ NO

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals): ❑ None

_____

_____

Do you ***NOW*** have diseases or conditions of: (Please check YES or NO). If yes, please specify if being treated and by whom.

Lungs:	**NO**	**YES**	
Bronchitis	❑	❑	_____
Emphysema	❑	❑	_____
Asthma	❑	❑	_____
ChronicCough	❑	❑	_____
Morning Cough	❑	❑	_____
Shortness of Breath	❑	❑	_____
Wheezing	❑	❑	_____

Cardiovascular:	**NO**	**YES**	
High Blood Pressure	❑	❑	_____
Chest Pain	❑	❑	_____
Heart Attack	❑	❑	_____
Heart Murmur or Mitral Valve Prolapse	❑	❑	_____
Irregular Heartbeat	❑	❑	_____
Phlebitis	❑	❑	_____
Inflammation of vein	❑	❑	_____
Blood clots	❑	❑	_____
Pacemaker	❑	❑	_____

OtherSystemic:	**NO**	**YES**	
Diabetes	❑	❑	_____
Excessive thirst/hunger	❑	❑	_____
Amputation	❑	❑	_____
Thyroid	❑	❑	_____
Kidney	❑	❑	_____
Dialysis	❑	❑	_____
Bladder	❑	❑	_____
Frequency/burning	❑	❑	_____
Gastrointestinal			
Stomach absorptive disorder	❑	❑	_____
Nausea, vomiting, diarrhea when taking antibiotics	❑	❑	_____
Yeast infection when taking antibiotics	❑	❑	_____
Arthritis/Joint Deformity	❑	❑	_____
Arthralgia	❑	❑	_____
Limited motion	❑	❑	_____
Artificial joint	❑	❑	_____
Convulsions, Epilepsy or Seizures	❑	❑	_____
Fainting	❑	❑	_____

List any other diseases or conditions: _____

and anyone who is treating you._____

List surgical procedures you have had in the last 6 months: _____

Skin: Have you ever had **skin** cancer/melanoma? ❑ NO ❑ YES If yes, Type? _____

Has anyone in your family had **skin** cancer/melanoma? ❑ NO ❑ YES If yes, Type? _____

Do you have a history of any specific skin diseases? ❑ NO ❑ YES If yes, Type? _____

Do you have problems with healing? ❑ NO ❑ YES

Do you develop keloids (scars) after surgery? ❑ NO ❑ YES

Do you bleed easily? ❑ NO ❑ YES

Do you develop skin rashes in reaction to ❑ Medications ❑ Food ❑ Environment ❑ Bandages ❑ Topical Neosporin ❑ Other_____

Social History:

Do you drink alcohol? ❑ NO ❑ YES If yes _____ drinks per day

Do you use IV drugs? ❑ NO ❑ YES If yes, what? _____ How often? _____

Do you smoke? ❑ NO ❑ YES If yes, how much: _____

Have you had or have been exposed to HIV (AIDS)? ❑ NO ❑ YES

Do you Tan? ❑ NO ❑ YES If yes, how: _____

Please answer the following questions:

(Women) Are you pregnant? ❑ NO ❑ YES Due Date: ___/___/___

What is your occupation? _____ Hobbies? _____

Completed by: ❑ Patient ❑ Other _____ Initials

_____ Signed by Patient

____/____/____ Date