Dermatology Medical History

Patient: _____ Date of Birth:_____/_____/_____Age:____Today's Date:_____/_____/_____

My Primary Care Doctor: _____

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	☐	☐	_____
Chronic Cough	☐	☐	_____
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	☐	☐	_____

Other Systemic:	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	If yes, Type?	_____
Do you develop keloids (scars) after surgery?	☐ NO	☐ Yes	If yes, Type?	_____
Do you bleed easily?	☐ NO	☐ Yes	If yes, Type?	_____

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 _____

_____ _____/_____/_____
Signed by Patient Date

Revised: 10-30-17