

# Dermatology Medical History

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for today's visit: \_\_\_\_\_

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

1. \_\_\_\_\_ 2. \_\_\_\_\_

Have you ever had dental anesthesia (Novocaine)?  YES  NO Any bad reaction?  YES  NO

List all medications you are currently taking (including prescriptions, over-the-counter-med., vitamins, and herbals):

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

<b>Lungs:</b>	<b>YES</b>	<b>NO</b>	<b>Other Systemic:</b>	<b>YES</b>	<b>NO</b>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Amputation	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
			Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cardiovascular:</b>	<b>YES</b>	<b>NO</b>	Gastrointestinal		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, vomiting, diarrhea		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection when		
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
<b>Pacemaker</b>			<b>Artificial joint</b>	<input type="checkbox"/>	<input type="checkbox"/>
			Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases or conditions: \_\_\_\_\_

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

Skin: Have you ever had skin cancer?  YES  NO  
Has anyone in your family had skin cancer?  YES  NO  
Do you have a history of any specific skin diseases?  YES  NO  
Do you have problems with healing?  YES  NO  
Do you develop keloids (scars) after surgery?  YES  NO  
Do you bleed easily?  YES  NO

Do you develop skin rashes in reaction to  Medications  Food  Environment  Bandages  Topical Neosporin  
 Other \_\_\_\_\_

## Social History:

Do you drink?  YES  NO If YES, \_\_\_\_\_ drinks per day  
Do you use IV drugs?  YES  NO If YES, what? \_\_\_\_\_ How often? \_\_\_\_\_  
Do you smoke or use tobacco products?  YES  NO If YES, how much: \_\_\_\_\_

Office use-Pamphlet given: \_\_\_\_\_

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

(Women) Are you pregnant?  YES  NO Due Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

What is your occupation? \_\_\_\_\_ Hobbies? \_\_\_\_\_

Completed by:  Patient \_\_\_\_\_ /\_\_\_\_/\_\_\_\_

Medical Assistant \_\_\_\_\_ Signed by Patient \_\_\_\_\_ Date \_\_\_\_\_

Initials \_\_\_\_\_ /\_\_\_\_/\_\_\_\_

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_