

# 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 meds., 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)

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

**Social History:**

Do you drink alcohol?  YES  NO If YES \_\_\_\_\_ drinks per day  
 Do you use IV drugs?  YES  NO If YES, what? \_\_\_\_\_ How often? \_\_\_\_\_  
 Do you smoke?  YES  NO If YES, how much: \_\_\_\_\_  
 Have you had or have you been exposed to HIV (AIDS)?  YES  NO

Please answer the following questions:

**(Women) Are you pregnant?**  YES  NO Due Date: \_\_\_ / \_\_\_ / \_\_\_  
 What is your occupation? \_\_\_\_\_ Hobbies? \_\_\_\_\_

Completed by:

Patient \_\_\_\_\_ / / \_\_\_\_\_ / / \_\_\_\_\_  
 Signed by Patient Date Updated Init

Med. Assist \_\_\_\_\_ / / \_\_\_\_\_ / / \_\_\_\_\_  
 Reviewed By Date Updated Init