# Dermatology Medical History

B·I·L·L·I·N·G·S Dermatology & Aesthetics

Patient: _____ 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 (Novocain)? ❑ YES ❑ NO Any bad reaction? ❑ YES ❑ NO

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

1:_____ 2:_____ 3:_____

4:_____ 5:_____ 6:_____

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

| **Lungs:** | **YES** | **NO** |
|---|---|---|
| Asthma | ❑ | ❑ |
| Bronchitis | ❑ | ❑ |
| Chronic Cough | ❑ | ❑ |
| Emphysema | ❑ | ❑ |
| Morning Cough | ❑ | ❑ |
| Shortness of Breath | ❑ | ❑ |

| **Cardiovascular:** | **YES** | **NO** |
|---|---|---|
| Blood Clots | ❑ | ❑ |
| Chest Pain | ❑ | ❑ |
| Heart Attack | ❑ | ❑ |
| Heart Murmur | ❑ | ❑ |
| High Blood Pressure | ❑ | ❑ |
| Inflammation of Vein | ❑ | ❑ |
| Irregular Heartbeat | ❑ | ❑ |
| *Pacemaker* | ❑ | ❑ |
| Phlebitis | ❑ | ❑ |

| **Other Systemic:** | **YES** | **NO** | |
|---|---|---|---|
| Arthralgia (Joint Pain) | ❑ | ❑ | |
| Arthritis' Joint Deformity | ❑ | ❑ | |
| Artificial Joint | ❑ | ❑ | |
| Bladder | ❑ | ❑ | |
| Convulsions, Epilepsy, Seizures | ❑ | ❑ | |
| Diabetes | ❑ | ❑ | |
| *Diabetic Neuropathy* | ❑ | ❑ | |
| Fainting | ❑ | ❑ | |
| *Lupus* | ❑ | ❑ | |
| *Metal Pins or Implants* | ❑ | ❑ | |
| *Scleroderma* | ❑ | ❑ | |
| *Therapeutic Gold Injections* | ❑ | ❑ | |
| Thyroid | ❑ | ❑ | |
| *Unrepaired Abdominal Hernia* | ❑ | ❑ | |
| Yeast Infection w/ Antibiotics | ❑ | ❑ | |
| *Herpes Simplex (Cold Sores)* | ❑ | ❑ | HSV |
| ESRD / Dialysis? | ❑ | ❑ | Screening |
| Allergic to acyclovir/valtrex? | ❑ | ❑ | Questions |

List any other diseases or conditions: _____

List surgical procedures you have had in the last 12 months: _____

Skin:

Have you ever had skin cancer? ❑ YES ❑NO If yes type: _____

Has anyone in your family had skin cancer? ❑ YES ❑ NO If yes type: _____

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

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? _____

**Social History:** ***Would You Like Info on Quitting?*** **/** *Staff Initial*

Do you use tobacco/vapor? ❑ YES ❑ NO If YES, What? _____ How much: _____ ***Tobacco*****: ❑*YES*** / _____

Do you drink alcohol? ❑YES ❑ NO If YES, Drinks per day: _____ ***Alcohol*****: ❑*YES*** / _____

Do you use IV drugs? ❑ YES ❑ NO If YES, What? _____ How often? _____ ***Drugs*****: ❑*YES*** / _____

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

*(Women) Are you pregnant?* ❑ YES ❑ NO Due Date:_____ *Breastfeeding?* ❑ YES ❑ NO

What is your occupation? _____ Hobbies? _____

**Completed by:** ❑ Patient ❑Medical Assistant, Initials____

_____

**Signed by Patient** **Date**

_____

**Reviewed by** **Date**

*Rev Sep 2021* **Updated Date/Initials:** _____ _____ _____ _____ _____