Dermatology Medical History

$B \cdot I \cdot L \cdot L \cdot I \cdot N \cdot G \cdot S$
Dermatology & Aesthetics

Gender Assigned at Birth: a M a F a Other	Patient:		Date:			07	<u> </u>	
Preferred Pronouns: He/Prim She/ther They/them Other Are you allergic to any medications? YES NO Key, list below: I. 2	Gender Assigned at Birth:	MoFo	Other		Gender Identity: 🗆 M 🗆 F 🗀 🤇	Other		
Are you allergic to any medications?								
Have you ever had dental anesthesia (Novocain)? U YES U NO Any bad reaction? U YES U NO List all medications you are currently taking (including prescriptions, over-the-counter medications, vitamins, and herbals): 1.	Are you alleraic to any med	dications	S D YES D NO) If vest lis	t below: 1	2		
List all medications you are currently taking (including prescriptions, over-the-counter medications, vitamins, and herbols): 1:	Have you ever had dental a	nesthes	ia (Novocain)	2 🗇 YES 🖂	INO Any had reaction?	LYES DINO		
herbals): 1: 2: 3: 4: 5: 6: 6: Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO) Lungs: YES NO Other Systemic: YES NO Asthma	•				•		vitamins and	
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Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO) Lungs: YES NO Other Systemic: YES NO Other Systemic: YES NO Asthma	4:		5:		6:			
Lungs: YES NO Other Systemic: YES NO Asthmad								
Asthma Bronchitis	-	-					=	
Bronchitis	_				Arthralgia (Joint Pain)		ב	
Bladder								
Convulsions, Epilepsy, Seizures								
Shortness of Breath	9							
Cardiovascular: YES NO Fainting	Morning Cough							
Cardiovascular: YES NO	Shortness of Breath							
Blood Clots								
Chest Pain			NO		•			
Heart Attack								
Heart Murmur					•			
High Blood Pressure								
Inflammation of Vein								
Irregular Heartbeat	•				•			
Herpes Simplex (Cold Sores) HSV Screening Hsv Screening Allergic to acyclovir/valtrex? Questions Screening Allergic to acyclovir/valtrex? Questions Screening Allergic to acyclovir/valtrex? Questions Allergic to acyclovir/valtrex? Questions Screening Allergic to acyclovir/valtrex? Questions Allergic to acyclovir/valtrex? Questions Ques					•	-		
ESRD / Dialysis? Screening Allergic to acyclovir/valtrex? Screening Allergic to acyclovir/valtrex? Screening Allergic to acyclovir/valtrex? Screening Allergic to acyclovir/valtrex? Questions								
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? Has anyone in your family had skin cancer? Do you have a history of any specific skin diseases? Do you have problems with healing Do you have problems with healing Do you develop keloids (scars) after surgery YES NO Do you bleed easily? Do you develop skin rashes in reaction to Medications Food Environment? Social History: Would You Like Into on Quitting? / Staff Initial Do you use tobacco/vapor? YES NO If YES, What? How much: Tobacco: YES / Do you use todacco/vapor? 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: Women) Are you pregnant? YES NO Due Date: Breastfeeding? YES NO What is your occupation? Completed by: Patient Medical Assistant, Initials Signature of Patient (or guardian) Date	FILEDILIS	_			· · · · · · · · · · · · · · · · · · ·		•	
List surgical procedures you have had in the last 12 months: Skin: Have you ever had skin cancer? Has anyone in your family had skin cancer? Do you have a history of any specific skin diseases? Do you have problems with healing Do you develop keloids (scars) after surgery Do you develop keloids (scars) after surgery 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, what? How often? Drugs: YES / Do you use IV drugs? YES NO If YES, what? How often? 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 Skin: NO If YES, What? How often? Hobbies? Date Reviewed by Date								
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Has anyone in your family had skin cancer?		cancera	<u>!</u>	□ YES	DNO If yes type:			
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Do you drink alcohol?	Do you use tobacco/vapor	S∃ AES	□ NO If YES, V	Vhat?	How much:	Tobacc	o: \(YES /	
Have you had or have you been exposed to HIV (AIDS)? □YES □ NO (Women) Are you pregnant? □ YES □ NO Due Date:	Do you drink alcohol? □Y!	ES 🗖 NO	If YES, Drinks	per day: _		Alcohol: 🛛 Yl	ES /	
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Completed by: Patient Medical Assistant, Initials Signature of Patient (or guardian) Date Date								
Completed by: Patient Medical Assistant, Initials Signature of Patient (or guardian) Date Date	(Women) Are you pregnant	,§ □ AES	□ NO Due D	ate:	Breastfeed	ding? 🗖 YES	□ NO	
Signature of Patient (or guardian) Date Date	What is your occupation? _				_ Hobbies?			
Signature of Patient (or guardian) Date Date			Assistant Initia	o.lo				
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Signature of Patient (or guardian) Reviewed by Date						/ /		
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Updated Date/Initials:	Reviewed by		Date					
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