Dermatology Medical History

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

Patient: _____ Date: _____

Gender Assigned at Birth: □ M □ F □ Other_____ Gender Identity: □ M □ F □ Other_____

Preferred Pronouns: ☐ He/him ☐ She/her ☐ They/them ☐ Other_____

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____

_____ _____/_____/_____

Signature of Patient (or guardian) Date

_____

Reviewed by **Date**

Updated Date/Initials: _____ _____ _____ _____ _____ *Rev 2/22*