

Dermatology Medical History

Patient: _____ Reason for Visit: _____

Referring Physician: _____ Primary Care Provider: _____

Are you allergic to any medications? YES NO If yes, list: 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 any of the diseases or conditions listed below: (Please check YES or NO)

Lungs:	YES	NO	Other Systemic:	YES	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia (Joint Pain)	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy, Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>			<i>Diabetic Neuropathy</i>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:	YES	NO	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<i>Lupus</i>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<i>Metal Pins or Implants</i>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<i>Scleroderma</i>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<i>Therapeutic Gold Injections</i>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of Vein	<input type="checkbox"/>	<input type="checkbox"/>	<i>Unrepaired Abdominal Hernia</i>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Yeast Infection w/Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>		
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	<i>Herpes Simplex (Cold Sores)</i>	<input type="checkbox"/>	<input type="checkbox"/>
			ESRD / Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
			Allergic to Acyclovir/Valtrex	<input type="checkbox"/>	<input type="checkbox"/>

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:

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: _____

