

# 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"/>
			Diabetic Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>
			Lupus	<input type="checkbox"/>	<input type="checkbox"/>
			Metal Pins or Implants	<input type="checkbox"/>	<input type="checkbox"/>
			Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>
			Therapeutic Gold Injections	<input type="checkbox"/>	<input type="checkbox"/>
			Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
			Unrepaired Abdominal Hernia	<input type="checkbox"/>	<input type="checkbox"/>
			Yeast Infection w/Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
			Herpes Simplex (Cold Sores)	<input type="checkbox"/>	<input type="checkbox"/> HSV
			ESRD / Dialysis	<input type="checkbox"/>	<input type="checkbox"/> Screening
			Allergic to Acyclovir/Valtrex	<input type="checkbox"/>	<input type="checkbox"/> 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:

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 \_\_\_\_/\_\_\_\_/\_\_\_\_

B · I · L · L · I · N · G · S

Dermatology & Aesthetics

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