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**
Asthma	☐	☐
Bronchitis	☐	☐
Chronic Cough	☐	☐
Emphysema	☐	☐
Morning Cough	☐	☐
Shortness of Breath	☐	☐

Cardiovascular:	**YES**	**NO**
Blood Clots	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
High Blood Pressure	☐	☐
Inflammation of Vein	☐	☐
Irregular Heartbeat	☐	☐
Pacemaker	☐	☐
Stroke	☐	☐

Other Systemic:	**YES**	**NO**
Arthralgia (Joint Pain)	☐	☐
Arthritis Joint Deformity	☐	☐
Artificial Joint, Metal Pins or Implants	☐	☐
Bladder	☐	☐
Convulsions, Epilepsy, Seizures	☐	☐
Diabetes	☐	☐
Fainting	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐
Lupus	☐	☐
Thyroid	☐	☐

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:

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_____/_____/_________