Dermatology Medical History

Patient: _____ Date of Birth:____/____/____ Today's Date:____/____/____

Reason for todays's visit:_____

Are you allergic to any medications? ☐ YES ☐ NO If yes, list below:

1._____ 2._____

Have you ever had dental anesthesia (Novacaine)? ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO

List all medications, dose & frequency, you are currently taking (Rx, over-the counter meds, vitamins, herbals):

1._____ 3._____ 5._____

2._____ 4._____ 6._____

Do you have now or have you ever had diseases or conditions of: (Please check ☐ YES or ☐ NO)

Lungs:	**YES**	**NO**
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐

Cardiovascular:		
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Vein inflammation	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐

Other Systemic	**YES**	**NO**
Diabetes	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Dialysis	☐	☐
Bladder	☐	☐
Gastrointestinal	☐	☐
Stomach absorptive disorder	☐	☐
Nausea, vomiting, diarrhea when taking antibiotics	☐	☐
Yeast infection when taking antibiotics	☐	☐
Arthritis/Joint Deformity	☐	☐
Arthralgia	☐	☐
Limited motion	☐	☐
Artificial joint	☐	☐
Convulsions, Epilepsy or Seizures	☐	☐
Fainting	☐	☐

List any other diseases or conditions: _____

List surgical procedures you have had within the last 6 months: _____

Skin:

Have you ever had skin cancer ☐ YES ☐ NO

Has anyone in your family had skin cancer? ☐ YES ☐ NO

Do you have a history of any specific skin diseases? ☐ YES ☐ NO If yes, _____

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 ☐Bandages ☐Topical Neosporin

Do you have a history of cold sores? ☐ YES ☐ NO

Social History:

Do you drink alcohol? ☐ YES ☐ NO If yes_____drinks per day

Do you use IV drugs? ☐ YES ☐ NO If yes, what?_____How often?_____

Do you smoke? ☐ YES ☐ NO If yes, how much? _____

Have you had or have you been exposed to HIV (AIDS)? ☐ YES ☐ NO

Please answer the following questions:

(Women) Are you pregnant? ☐ YES ☐ NO

What is your occupation?_____Hobbies? _____

Completed by: ☐ Patient _____ ___/___/___ ___/___/___ _____

☐ Med. Assist_____ Signed by Patient Date Updated Initials

Initials

_____ ___/___/___ ___/___/___ _____

Reviewed by Date Updated Initials