

Dermatology Medical History

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

Reason for today's visit: _____ Pharmacy Info: _____

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

1. _____ 2. _____

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

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and 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)

	YES	NO		YES	NO
Lungs:			Other Systemic:		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Amputation	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
			Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:			Gastrointestinal		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, vomiting, diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizure, Fainting	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases or conditions: _____

List surgical procedures you have had in 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

Other _____

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

(Women) Are you pregnant? YES NO Due Date: ___/___/___

Referred by: _____

What is your occupation? _____ Hobbies? _____

Completed by: Patient _____ / / _____ / / _____
 Med. Assist _____ Signed by Patient _____ Date _____ Updated _____ Init _____
Initials

Reviewed by _____ / / _____ / / _____
 Date _____ Updated _____ Init _____