Dermatology Medical History

Patient:_____ Date: _____/_____/_____

Reason for today's visit:_____

Name of Primary Care Physician:_____

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

1._____ 2._____ 3._____

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:
(Or attach a copy of your medication list)

1._____ 2._____ 3._____

4._____ 5._____ 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	☐	☐
Chronic Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐

Cardiovascular:	YES	NO
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Inflammation of vein	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐

Other Systemic:	YES	NO
Diabetes	☐	☐
Excessive thirst/hunger	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Bladder	☐	☐
Frequency/burning	☐	☐
Gastrointestinal		
Stomach absorptive disorder	☐	☐
Nausea, vomiting, diarrhea		
when taking antibiotics	☐	☐
Yeast infection		
when taking antibiotics	☐	☐
Arthritis/Joint Deformity	☐	☐
Limited Motion	☐	☐
Artificial Joint	☐	☐
Convulsions, Epilepsy or Seizures	☐	☐
Fainting	☐	☐

List any other conditions or diseases:_____

List surgical procedures you have had in the past 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 any 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 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 ever had or have you been exposed to HIV (AIDS)? ☐ YES ☐ NO

Please answer the following questions:

WOMEN: Are you pregnant? ☐ YES ☐ NO Due Date:_____

What is your occupation?_____ Hobbies?_____

Completed by: ☐ Patient ☐ Parent/Guardian ☐ Other: _____

Patient/Guardian Signature: _____ **Date:**_____ **Reviewed by:**_____ **Date:**_____