DERMATOLOGY MEDICAL HISTORY

PATIENT:	DATE OF BIRTH:	TODAY"S DATE:

Are you allergic to any medications? **YES** **NO** If yes, list below & explain reaction:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Are you allergic to: **Lidocaine** **Latex** **Bandages** **Metal/Jewelery** (Circle)

List all medications you are currently taking (include prescription, over-the-counter, vitamins, herbs)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Do you bleed easily? **YES** **NO** Do you take? **Daily Aspirin** **Coumadin** (Circle)

Do you take antibiotics for dental procedures? **YES** **NO** Why? _____

Do you have now, or have you ever had: (Please check)

LUNGS:	**YES**	**NO**
Allergies/Hay Fever	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Chronic Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐

HEART AND BLOOD VESSELS:	**YES**	**NO**
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Blood Clots	☐	☐
Inflamation of Veins	☐	☐
Pacemaker/Defibrillator	☐	☐
Artificial Heart Valve	☐	☐

OTHER:	**YES**	**NO**
Diabetes	☐	☐
Type I	☐	☐
Type II	☐	☐
Thyroid Disease	☐	☐
Underactive Thyroid	☐	☐
Overactive Thyroid	☐	☐
Kidney Disease	☐	☐
Dialysis	☐	☐
Liver Disease	☐	☐
Hepatitis	☐	☐
Arthritis/Joint Disorders	☐	☐
Artificial Joint	☐	☐
Seizure Disorder	☐	☐
Stroke	☐	☐
Fainting Episodes	☐	☐
Organ Transplant	☐	☐
Depression	☐	☐
Anxiety	☐	☐

List any other diseases or conditions: _____

List surgical procedures in the past 6 months: _____

SKIN:	**YES**	**NO**
Skin Cancer	☐	☐
Basal Cell Carcinoma	☐	☐
Squamous Cell Carcinoma	☐	☐
Melanoma	☐	☐
Psoriasis	☐	☐
Eczema	☐	☐
Acne	☐	☐

	YES	**NO**
Problems with skin healing?	☐	☐
Develop thick scars/keloids	☐	☐
Other Skin Disorders (List)	☐	☐

_____
_____
_____
_____

PATIENT SIGNATURE _____ DATE _____ PHYSICIAN SIGNATURE /DATE _____

DERMATOLOGY MEDICAL HISTORY

PATIENT:	DATE OF BIRTH:	TODAY"S DATE:

SOCIAL HISTORY: **YES** **NO**

Do you drink coffee? ☐ ☐ If YES, _____ 8 oz cups/day
Do you drink colas? ☐ ☐ If YES, _____ cans/day
Do you drink alcohol? ☐ ☐ If YES, _____ drinks per day
Do you use IV drugs? ☐ ☐ If YES, what? _____ How often? _____
Do you smoke? ☐ ☐ If YES, how much? _____

Are you under stress? ☐ ☐
Do you exercise? ☐ ☐ If YES, how many times/week? _____
Do you play any sports? ☐ ☐ If YES, which ones? _____
How many hours do you sleep? _____ Hours

Do you use sunscreen? ☐ ☐ If YES, SPF? _____
Have you ever had a blistering sunburn? ☐ ☐ If YES, how many times? _____
Do you/have you used tanning beds? ☐ ☐

When exposed to sun do you? **Tan only** **Tan & Burn** **Burn only**

Do you have high risk factors for HIV, hepatitis exposure, or tuberculosis? **YES** **NO**

Occupation? _____

FOR WOMEN ONLY **YES** **NO**

Yeast Infections with Oral Antibiotics? ☐ ☐
Are you pregnant? ☐ ☐ If YES, Due Date: _____
Are you planning pregnancy within next 12 months? ☐ ☐
Are you breast feeding? ☐ ☐

FAMILY HISTORY **YES** **NO**

Skin Cancer ☐ ☐ If YES, who and what kind?
_____
_____
_____

Psoriasis ☐ ☐ If YES, who? _____
Eczema ☐ ☐ If YES, who? _____
Allergies/Hay Fever ☐ ☐ If YES, who? _____
Asthma ☐ ☐ If YES, who? _____
Diabetes ☐ ☐ If YES, who? _____
Thyroid Disease ☐ ☐ If YES, who? _____

PATIENT SIGNATURE _____ DATE _____ PHYSICIAN SIGNATURE /DATE _____