

Dermatology Medical History

Patient: _____

Date: ___/___/___

Reason for today's visit: _____

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"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal		
			Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:			Nausea, vomiting, diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection when		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	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? _____

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 Due Date: ___/___/___
- What is your occupation? _____ Hobbies? _____

Completed by: Patient _____ Medical Assistant _____
 Initials _____ Signed by Patient _____ Date ___/___/___
 Reviewed by _____ Date ___/___/___