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 (Novocain)? □ 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)

Lungs:	YES	NO
Bronchitis	□	□
Emphysema	□	□
Asthma	□	□
Chronic Cough	□	□
Morning Cough	□	□
Shortness of breath	□	□
Wheezing	□	□

Cardiovascular	YES	NO
High Blood Pressure	□	□
Chest Pain	□	□
Heart Attack	□	□
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	□	□
Arthralgia	□	□
Limited motion	□	□
Artificial joint	□	□
Convulsions, Epilepsy or Seizures	□	□

List any other diseases or conditions:_____

List surgical procedures you have had int 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 disease? □ 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 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 _____ Initals

_____Date:_____
Signed by Patient

_____Date_____
Reviewed by