Dermatology Medical History

Patient: ______________________________ Date: ______________

Reason for today's visit: ______________________________

Are you allergic to any medications? ☐ yes ☐ NO If Yes List:
1. ______________________ 2. ______________________

Have you ever had dental anesthesia (Novacaine0? ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO

List all medications you are currently taking (including prescription, over-the-counter meds., vitamins, and herbals):
1. ______________________ 3. ______________________
2. ______________________ 4. ______________________

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	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Inflammation of vein	☐	☐
Bloodclots	☐	☐
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	☐	☐
Fainting	☐	☐

Skin:

When you are exposed to sun do you: ☐ Tan only ☐ Tan & burn ☐ Burn
Have you ever had skin cancer? ☐ YES ☐ NO
Has anyone in your family had skin cancer? ☐ YES ☐ NO IF YES, Who? ____________
Do you have a history of any specific skin diseases? ☐ YES ☐ NO
If yes, please list:

____

Do you develop skin rashes in reaction to ☐ Medications ☐ Food ☐ Environment? ____________

List any other diseases or conditions: ______________________________
List surgical procedures you have in the last 6 months: ______________________________

Social History:

Do you drink alcohol? ☐ YES ☐ NO If YES________ drinks per day
Do you IV drugs? ☐ YES ☐ NO If YES, what? ____________ How much? ____________
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:

A. Do you bleed easily? ☐ YES ☐ NO
B. (Woman) Are you Pregnant? ☐ YES ☐ NO Due Date: ____________
C. What is your occupation? ______________________________
D. What are your hobbies? ______________________________

Completed by: ☐ Patient
☐ Medical Assistant __________
Initials

____
Signed by Patient Date

____
Reviewed by Date