DERMATOLOGY MEDICAL HISTORY

Patient: _____ Date: _____/_____/_____

What is your reason for todays visit? _____

Are you allergic to any medications? ☐ Yes ☐ No If yes, please explain below
1) _____ 2) _____

Have you ever had dental anesthesi ☐ Yes ☐ No Any bad reactions? ☐ Yes ☐ No

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

Do you have now, or have you ever had diseases or conditions of: (Please check yes or no)

Lungs

Bronchitis	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Chronic cough	☐ Yes	☐ No
Seasonal Allergies	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No

Cardiovascular

High Blood Pressure	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Irregular hear beat	☐ Yes	☐ No
Phlebitis	☐ Yes	☐ No
Inflamation of vein	☐ Yes	☐ No
Blood Clots	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No

Other Systemic

Diabetes	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Thyroid Disorder	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Organ Transplant	☐ Yes	☐ No
Immune System Disorder	☐ Yes	☐ No
Bleeding or Blood Disorder	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Gastrointestinal Disorder	☐ Yes	☐ No
Autoimmune Disease	☐ Yes	☐ No
Yeast infection when taking antibiotics	☐ Yes	☐ No
Arthritis/ Joint Deformity	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No
Convulsions, Epilepsy or Seizures	☐ Yes	☐ No
Fainting	☐ Yes	☐ No

List any other diseases or conditions _____

List any surgical procedures you have had in the past six months _____

Skin:

Have you ever had skin cancer?	☐ Yes	☐ No	Type_____
Has anyone in your family had skin cancer?	☐ Yes	☐ No	Type_____
Do you have a history of any specific skin diseases?	☐ Yes	☐ No	
Do you have problems with healing?	☐ Yes	☐ No	
Do you develop keloids (scars) after surgery?	☐ Yes	☐ No	
Do you have a history of blistering sunburns?	☐ Yes	☐ No	
Do you have a history of tanning bed use?	☐ Yes	☐ No	

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 _____ Signed by Patient Date

_____ _____/_____/_____
Reviewed by Date