

# DERMATOLOGY MEDICAL HISTORY

Patient: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

What is your reason for today's visit? \_\_\_\_\_

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

Have you ever had dental anesthesia?  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

## 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  
Artificial Joint  Yes  No  
Fainting  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  
Inflammation of vein  Yes  No  
Blood Clots  Yes  No  
Pacemaker  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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_