

DERMATOLOGY MEDICAL HISTORY

Patient: _____ Date: ____/____/____

Reason for today's visit: _____

How long has this problem been present? _____ Has it been treated before? _____

Are you allergic to any medications? Yes ____ No ____ If yes, list below:

1. _____ 2. _____

Reaction: _____ Reaction: _____

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., aspirin, 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 | Other Systemic: | YES | NO |
|----------------------------|-----|-----|-----------------------------------|-----|-----|
| Lungs: | | | Diabetes | ___ | ___ |
| Asthma | ___ | ___ | Glaucoma | ___ | ___ |
| T.B. | ___ | ___ | Liver disease/Hepatitis | ___ | ___ |
| Cardiovascular | ___ | ___ | Thyroid Disorder | ___ | ___ |
| Heart Attack | ___ | ___ | Kidney disease | ___ | ___ |
| High Blood Pressure | ___ | ___ | Gastrointestinal ulcer | ___ | ___ |
| Congestive Heart Failure | ___ | ___ | GERD (Reflux Disease) | ___ | ___ |
| Heart Murmur | ___ | ___ | Cancer | ___ | ___ |
| Phlebitis | ___ | ___ | Area: _____ | | |
| Inflammation of vein | ___ | ___ | HIV | ___ | ___ |
| Blood clots | ___ | ___ | AIDS | ___ | ___ |
| Pacemaker | ___ | ___ | Artificial joint | ___ | ___ |
| Defibrillator | ___ | ___ | Arthritis | ___ | ___ |
| Irregular heartbeat | ___ | ___ | Convulsions, Epilepsy or Seizures | ___ | ___ |
| Autoimmune disorder | ___ | ___ | | | |

List any other diseases or conditions: _____

List surgical procedures you have had: _____

Skin:

Have you ever had skin cancer? Yes ____ No ____ If yes, what kind? _____

Has anyone in your family had skin cancer? Yes ____ No ____ If yes, what kind? _____

Do you have a history of any specific skin diseases? Yes ____ No ____ If yes, what kind? _____

Do you have problems with healing? Yes ____ No ____

Do you bleed easily? Yes ____ No ____

Do you form Keloids? Yes ____ No ____

Do you get cold sores? 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 wk.

Do you use IV or recreational drugs? Yes ____ No ____ If Yes, what? _____ How often? _____

Do you smoke? Yes ____ No ____ If Yes, how much: _____

Women, please answer the following questions:

Are you pregnant or nursing? Yes ____ No ____ Due Date: ____/____/____

Do you have regular menstrual periods? Yes ____ No ____ Date of last menstrual period _____

Menopause Yes ____ No ____

Completed by: ____ Patient or ____ Guardian

Reviewed:

Signed by Patient/Guardian

____/____/____
Date