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 (Novocaine)? □YES □NO Any bad reaction? □YES □NO

List all medications you are currently taking (including prescriptions, over-the-counter, 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	□	□
Heart Murmur	□	□
Irregular Heartbeat	□	□
Phlebitis	□	□
Inflammation of Vein	□	□
Blood Clots	□	□
Pacemaker	□	□

Other System:	**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	□	□

List any other diseases or conditions: _____

List surgical procedures you have had in 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 diseases? □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 □Medication □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 have 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 _____ Initials

_____ ____/____/____
Signed by Patient Date

_____ ____/____/____
Reviewed by Date