

# DERMATOLOGY MEDICAL HISTORY

Patient: \_\_\_\_\_ Age: \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_ Are you allergic to any medications?  Yes  No

If yes, please specify: ① \_\_\_\_\_ ② \_\_\_\_\_ ③ \_\_\_\_\_

Are you allergic to dental anesthesia (Novocaine)?  Yes  No Latex allergy?  Yes  No

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals): Use back if necessary

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 4. _____ | 7. _____ |
| 2. _____ | 5. _____ | 8. _____ |
| 3. _____ | 6. _____ | 9. _____ |

**Please check if you have or ever had the following diseases/conditions:**

<u>Lungs:</u>	Yes	No	If yes, please explain	<u>Skin Diseases, cont' d:</u>	Yes	No	If yes, please explain
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____	Atopic dermatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	_____
TB (tuberculosis)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Athlete's foot	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Cardiovascular:</u>				Finger / Toenail fungus	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mycosis Fungoides	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
CVA / stroke				<u>Other Diseases:</u>			
<b>Pacemaker</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Defibrillator</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Artificial Joint</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Heart Valve</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bladder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Convulsions, epilepsy, seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____	Prostate	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gastrointestinal:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	(stomach, colon, liver)			
<u>History of Skin Disease(s):</u>				Hepatitis A, B or C ( <i>circle one</i> )	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Have you had skin cancer?</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Arthritis / Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Have you had melanoma?</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Actinic Keratosis ("Pre-cancers")</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Chemotherapy / Radiation?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Family member had melanoma?</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Family member had skin cancer?</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Do you bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dandruff / flaky or itchy scalp	<input type="checkbox"/>	<input type="checkbox"/>	_____	Do you develop keloids			_____
Rosacea	<input type="checkbox"/>	<input type="checkbox"/>	_____	(thick scars) after surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Acne	<input type="checkbox"/>	<input type="checkbox"/>	_____	<u>Female Problems:</u>			
Warts	<input type="checkbox"/>	<input type="checkbox"/>	_____	Breast, ovaries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fever / Skin Blisters	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

List Surgical Procedures / Hospitalizations: \_\_\_\_\_

Social History:

Do you drink alcohol?  Yes  No If Yes, \_\_\_\_\_ drinks per day

Do you smoke?  Yes  No If Yes, how much? \_\_\_\_\_

Have you had or ever been exposed to HIV (AIDS)?  Yes  No

Family History: (Cancer, T.B., High Blood Pressure, Heart Disorder, Diabetes, Asthma, Allergies, etc.): \_\_\_\_\_

Pregnant?  Yes  No  NA Due Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ LMP: \_\_\_\_\_

Completed by:  Patient/Parent/Guardian  
 Medical Assistant \_\_\_\_\_ (Initials)



Signed by Patient/Parent/Guardian	_____/_____/_____
Reviewed by Provider	_____/_____/_____

Reviewed by / Date	Reviewed by / Date	Reviewed by / Date	Reviewed by / Date
Reviewed by / Date	Reviewed by / Date	Reviewed by / Date	Reviewed by / Date
Reviewed by / Date	Reviewed by / Date	Reviewed by / Date	Reviewed by / Date