DERMATOLOGY MEDICAL HISTORY

Patient: _____ Date of Birth: ___/___/___ Today's 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 meds, 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		
High Blood Pressure	☐	☐
Chest pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Plebitis	☐	☐
Inflammation of vein	☐	☐
Blood Clots	☐	☐
Pacemaker	☐	☐

Other Systemic:	YES	NO
Diabetes	☐	☐
Excessive thirt/hunger	☐	☐
Amputation	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Dialysis	☐	☐
Bladder	☐	☐
Frequency/Burning	☐	☐
Gastrointestinal		
Stomach adsorption 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 any 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 disease? ☐ 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 ☐ Bandages ☐ Topical Neosporin ☐ Other: _____

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: Date: ___/___/___
What is occupation? _____ Hobbies? _____

Completed by: Patient _____ ___/___/___
Signed by Patient Date

Medical Assistant _____
Initials

_____ ___/___/___
Reviewed by Date