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 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:	**YES**	**NO**
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Phlebitis	❑	❑
Inflammation of vein	❑	❑
Blood clots	❑	❑
Pacemaker	❑	❑

Other Systemic:	**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 ❑ Medications ❑ 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 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 ________ Initials

______________________ Signed by Patient ___/___/___ Date

______________________ Reviewed by ___/___/___ Date

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