Dermatology Medical history Today's date: ___________________

Patient: ____Date of Birth: _____________ Are you pregnant ☐Yes ☐ No Due Date: ______________

Reason for today's visit: ____

Are you allergic to any mediations? ☐ Yes ☐ No If yes, list below:

1. ____ 2. ____

Have you ever had dental anesthesia (Novocain)? ☐ Yes ☐ No Any bad reactions? ☐ Yes ☐ No

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

1. ______________________ 2. ______________________ 3. ______________________

4. ______________________ 5. ______________________ 6. ______________________

7. ______________________ 8. ______________________ 9. ______________________

Do you now have, 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	☐	☐
Heat Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Inflammation of vein	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐

Other systemic:	**Yes**	**No**
Diabetes	☐	☐
Excessive thirst/hunger	☐	☐
Fainting	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Dialysis	☐	☐
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	☐	☐

List any other diseases or conditions________________________________

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List surgical procedures you have had in the last 6 months _____________________

____

Skin:	**Yes**	**No**
Have you ever had skin cancer?	☐	☐
Do you bleed easily?	☐	☐
Do you develop keloids (scars) after surgery	☐	☐
Do you have a history of any specific skin diseases?	☐	☐

	Yes	**No**
Has anyone in your family had skin cancer?	☐	☐
Do you have problems with healing?	☐	☐

If yes please list ____

Do you develop skin rashes in reaction to ☐Medications ☐Food ☐Environment ☐Bandages ☐Topical Neosporin ☐Other _________________________

Social history:

Do you drink alcohol? ☐ Yes ☐ No If Yes _________drinks per day week month year (circle one)

Do you use IV drugs? ☐ Yes ☐ No If Yes what? ____

Do you smoke? ☐ Yes ☐ No If Yes how much? ______________________What age did you begin? ____________

Have you had or have you been exposed to HIV (AIDS) ☐ Yes ☐ No

What is your occupation? ____

What are your hobbies? ____

Signed by Patient _______________________________________ Date ___/___/______ Updated ___/___/______ Int. ___________

Reviewed by ____ Date ___/___/______ Updated ___/___/______ Int. ____________

Completed by ☐ patient ☐ medical assistant _________Initials