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**
Asthma	□	□
Bronchitis	□	□
Chronic Cough	□	□
Emphysema	□	□
Morning Cough	□	□
Shortness of Breath	□	□

CardioVascular	**YES**	**NO**
High Blood Pressure	□	□
Chest Pain	□	□
Heart Attack	□	□
Heart Murmur	□	□
Irregular Heartbeat	□	□
Phlebitis	□	□
Blood Clots	□	□
PACEMAKER	□	□
Antibiotic Prophylaxis	□	□
Convulsions, Epilepsy	□	□
Seizures, Fainting	□	□

Other Systemic:	**YES**	**NO**
Diabetes	□	□
Excessive Thirst/Hunger	□	□
Amputation	□	□
Thyroid Disease	□	□
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(s)	□	□

List any other disease 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 □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 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? _____

Completed by: □ Patient _____ __/__/__ __/__/__ ____
Signed by Patient Date Updated Init

□Med Assist: _____
Init _____ __/__/__ __/__/__ ____
Reviewed by Date Updated Init