Dermatology Medical History

Patient_____Date of birth_____ Todays date_____
Reason for today's visit_____
Are you allergic to any medications? ☐yes ☐no If yes, list below:_____
_____
Have you ever had dental anesthesia (Novocaine)? ☐yes ☐no Any bad reaction? ☐yes ☐no
List all medications your are currently taking (including over the counter meds, vitamins, herbals)
1._____ 2._____ 3._____
4._____ 5._____ 6._____
Do you have now or have you ever had disease 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	☐	☐
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, Seizures Fainting	☐	☐

List any other diseases or conditions:_____
List surgical procedures you have had in the last 6 months:_____
_____

Skin: Have you ever had a 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
Do you have any 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 ☐Neosporin ☐other_____

Social History:
Do you drink alcohol? ☐yes ☐no if yes_____drinks a 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 ever been exposed it HIV (AIDS)? ☐yes ☐no
Are you pregnant? ☐yes ☐no due date_____
What is your occupation?_____Hobbies?_____

_____ _____
Patient Signature Date