

Dermatology Medical History

Patient: _____ Age: _____

Reason for visit: _____

Are you allergic to any medications? Yes No If yes, please list below:

1. _____ 2. _____

Have you ever had a bad reaction to dental anesthesia (Novocaine)? Yes No

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Have you ever had the following diseases or conditions: (Please check YES or NO)

	YES	NO		YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, vomiting, diarrhea when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infections when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases or conditions: _____

Surgical history: _____

Skin: Have you ever had skin cancer? YES NO If yes, circle type:
Basal Cell Squamous Cell Melanoma

Has anyone in your family had skin cancer? YES NO If yes, circle type:
Basal Cell Squamous Cell Melanoma

Do you have a history of any skin diseases? YES NO If yes, which type: _____

Do you have problems with healing? YES NO

Do you develop scars after surgery? YES NO

Do you bleed easily? YES NO

Do you develop skin rashes from: Medications Food Environment Bandages Neosporin
 Other _____

Social History:

Do you drink alcohol? YES NO If YES, _____ drinks per day

Do you smoke? YES NO If YES, how much? _____

If female, are you pregnant? YES NO If YES, expected due date: ____/____/____

What is your occupation? _____ Hobbies? _____

Completed by: Patient _____ / _____ / _____
 Medical Assistant _____ Signed by Patient _____ Date _____
Initials