

# 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	Other Systemic:	YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Amputation	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
			Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
			Gastrointestinal		
			Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
			Nausea, vomiting, diarrhea		
			when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
			Yeast infection when		
			taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
			Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
			Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
			Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
			Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
			Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>

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  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? \_\_\_\_\_ Hobbies? \_\_\_\_\_

Completed by:  Patient \_\_\_\_\_  
 Medical Assistant \_\_\_\_\_  
Initials

Signed by Patient \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Reviewed by \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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