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**
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	❑	❑
Bladder	❑	❑
Frequency/burning	❑	❑
Gastrointestinal		
Stomach absorptive disorder	❑	❑
Nausea, vomiting, diarrhea		
when taking antibiotics	❑	❑
Yeast infection when		
taking antibiotics	❑	❑
Arthritis/Joint Deformity	❑	❑
Arthraigia	❑	❑
Limited motion	❑	❑
Artificial joint	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Fainting	❑	❑

List any other diseases or conditions: _____
Do you have now, or have you ever had Hepatitis ❑ YES ❑ NO If Yes, what type? _____
Have you had or have you been exposed to HIV (AIDS)? ❑ YES ❑ NO
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? _____

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: _____

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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