Sex: Female __ Male__

Ethnicity/Race:_____

# Dermatology Medical History (2020)

**Patient Name**:_____ **Date**:_____/_____/_____

Reason for today's visit:_____

Does anyone in your family have this problem? ☐ Yes ☐No If yes who:_____

The following information is very important to your health. Please take time to **fully and completely fill out** this important information.

Any Medication **Allergies**? ☐ Yes ☐No if yes **what:**_____

**Please list **Reaction**/ When (i.e.: Codein/Rash/1999(Year)**:**_____

List all medications you are currently taking including strength (ie: Lipitor 10 mg) including OTC **or Can Provide a List**

1._____2._____3._____4._____5._____

Do you have now or have you ever had any of the problems below? Please check Yes or No

| **Lungs:** | **Yes** | **No** | **Other Systemic:** | **Yes** | **No** | **Elaborate** |
|---|---|---|---|---|---|---|
| Bronchitis | ☐ | ☐ | Diabetes | ☐ | ☐ | Type:_____ |
| Emphysema | ☐ | ☐ | Dementia | ☐ | ☐ | |
| Asthma | ☐ | ☐ | Depression | ☐ | ☐ | |
| Chronic Cough | ☐ | ☐ | Thyroid Disease | ☐ | ☐ | Hyper or Hypo_ |
| COPD | ☐ | ☐ | Kidney Disease | ☐ | ☐ | |
| Wheezing | ☐ | ☐ | Dialysis | ☐ | ☐ | |
| Pneumonia | ☐ | ☐ | Gastrointestinal | ☐ | ☐ | |
| **Cardiovascular:** | **Yes** | **No** | Ulcer | ☐ | ☐ | |
| High Blood Pressure | ☐ | ☐ | GERD | ☐ | ☐ | |
| Stroke | ☐ | ☐ | Stomach absorptive disorder | ☐ | ☐ | Type:_____ |
| Heart Murmur | ☐ | ☐ | Arthritis | ☐ | ☐ | |
| Chest Pain | ☐ | ☐ | Epilepsy, Seizures | ☐ | ☐ | |
| Stent | ☐ | ☐ | **History of Skin Cancer** | ☐ | ☐ | Type:_____ |
| Phlebitis | ☐ | ☐ | **Artificial Joint** | ☐ | ☐ | Where:_____ |
| **Pacemaker** | ☐ | ☐ | **Amputation** | ☐ | ☐ | Where:_____ |

List any other diseases or conditions (or surgeries in the last 6 mo): _____

_____

**Skin:** Do you have any history of Herpes Simples (Fever Blisters, Cold Sores ☐ Yes ☐No Last Breakout:_____ ___

Do you have any history of Herpes Zoster (Shingles)?☐ Yes ☐No Last Breakout _____

Do you have any sensitivity to antibiotics? ☐ Yes ☐No What: yeast infections/upset stomach_____

Do you develop keloids(raised scars) after surgery? ☐ Yes ☐No

Do you develop skin rashes from: ☐ Bandages ☐ Neosporin ☐ Other _____

**Social History:**

Do you drink alcohol? ☐ Yes ☐No if yes, (how many)_____beer/ wine/ liquer per Day /Week /Month /Ocassional (circle answer)

Do you use tobacco/smoke? ☐ Yes ☐No **or** Have you ever? ☐ Yes ☐No if yes, What? Cigarette/cigar/pipe/chew/dip

Currently how much: _____ **or** When did you quit? _____

History of Substance use or IV drugs? ☐ Yes ☐No if yes, What? _____ How often:_____

**General Medical History:**

Do you have Hep, HIV (AIDS)?☐ Yes ☐No or have you ever been exposed? ☐ Yes ☐No

Age 65+: Have you had pneumonia vaccination? ☐ Yes ☐No When (year):_____

Age 50-75: Have you had Colorectal Cancer screening? ☐ Yes ☐No When:_____Colonoscopy/FOBT/Sigmoidoscopy

Women: Are you Pregnant? ☐ Yes ☐No Due date:___/___/___

Age 40-69: Have you had a Mammogram? ☐ Yes ☐No When (Year):_____

Age 21-64: Have you had Cervical Cancer screening (PapTest)? ☐ Yes ☐No When (year):_____

What is your occupation? _____ ☐ retired ☐ student Hobbies? _____

**Preferred Pharmacy:** _____ **Cross Streets** (or address if know it)**:**_____

**The above is true and correct to the best of my belief.**

****Patient Signature**: _____ Form Completed by: ☐ Patient

☐ _____

Reviewed with patient by: _____ ,MA Any MA Notes:_____ (Entered in EMR: ☐)