

Sex: Female ___ Male ___

Ethnicity/Race: _____

Dermatology Medical History (2018)

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 (ie: 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

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