DERMATOLOGY MEDICAL HISTORY

Patient Name: ___________________________________ DOB_____/_____/______ Date: _____/______/_____

Reason for your visit:____

Are you allergic to any medications: Yes ___No ___ If yes please list: _______________________________

Have you ever had a bad reaction to dental anesthesia? Yes ___No ___ Never had dental anesthesia ____

List all medications you are currently taking (including prescription, over-the-counter, vitamins, and herbals)

1. __________________________ 2. __________________________ 3. __________________________

4. __________________________ 5. __________________________ 6. __________________________

Do you have now or have you ever had diseases or conditions of: (Please check yes or no)

Lungs:

Bronchitis	Yes ___	No ___
Emphysema/COPD	Yes ___	No ___
Asthma	Yes ___	No ___

Heart:

High Blood Pressure	Yes ___	No ___
Heart Attack	Yes ___	No ___
Cholesterol issues	Yes ___	No ___
Heart murmur	Yes ___	No ___
Irregular Heartbeat	Yes ___	No ___
Blood clots	Yes ___	No ___
Pacemaker	Yes ___	No ___
Coronary Artery Disease	Yes ___	No ___

Endocrine:

Diabetes	Yes ___	No ___
Thyroid (Which one: Hypo or Hyper)	Yes ___	No ___
Kidney	Yes ___	No ___
Dialysis	Yes ___	No ___
	Yes ___	No ___

Cancer:

Type of cancer: ____________________

GI:

Reflux	Yes ___	No ___
Stomach problems	Yes ___	No ___
Irritable Bowel	Yes ___	No ___

GU:

Bladder problems	Yes ___	No ___
Yeast infections with antibiotics	Yes ___	No ___

Rheumatologic

Arthritis	Yes ___	No ___
Artificial joint	Yes ___	No ___

Neurologic

Memory problems	Yes ___	No ___
Hearing Loss	Yes ___	No ___
Seizures/Fainting	Yes ___	No ___
Headaches	Yes ___	No ___
Stroke	Yes ___	No ___

Psychological

Depression	Yes ___	No ___
Anxiety	Yes ___	No ___

Are you currently experiencing any of the following: (Please check yes or no)

Excessive weight loss	Yes ___	No ___	Headaches	Yes ___	No ___
Fevers/chills	Yes ___	No ___	Enlarged lymph nodes	Yes ___	No ___
Night sweats	Yes ___	No ___	Nausea/vomiting	Yes ___	No ___

List any other diseases or conditions: ____

List any major surgeries and the year they were performed: ____

Skin:

Have you ever had skin cancer? Yes ___No ___ if yes: _________________________

Has anyone in your family had skin cancer? Yes ___No ___ if yes: _________________________

Do you have a history of a skin disease? Yes ___No ___ if yes: _________________________

Do you have problems with healing? Yes ___No ___

Do you develop keloids (scars) after surgery? Yes ___No ___

American Academy of Dermatology Association

Do you bleed easily? Yes ___No ___
Do you develop rashes to bandages or Neosporin? Yes ___No ___

Social History:

Do you drink alcohol? Yes ___No ___ if yes #____________ drinks per day
Do you or have you ever used social drugs? Yes ___No ___ if yes, what type? _______________________
Do you smoke? Yes ___No ___ if yes, how much?_______________________
Have you ever smoked? Yes ___No ___ Year quit? ______________
Are you infected with HIV/AIDS Yes ___No ___
What is your occupation? ________________________________ Hobbies? _________________________

(Women) Are you pregnant? Yes ___No ___ Due Date: ___/____/_________________

Patient Signature: __________________________Date:__/___/__ Reviewed by: ____________Date:__/___/__