

# 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 \_\_\_

**GI:**

Reflux Yes \_\_\_ No \_\_\_  
Stomach problems Yes \_\_\_ No \_\_\_  
Irritable Bowel 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 \_\_\_

**GU:**

Bladder problems Yes \_\_\_ No \_\_\_  
Yeast infections with antibiotics Yes \_\_\_ No \_\_\_

**Rheumatologic**

Arthritis Yes \_\_\_ No \_\_\_  
Artificial joint Yes \_\_\_ No \_\_\_

**Endocrine:**

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

**Neurologic**

Memory problems Yes \_\_\_ No \_\_\_  
Hearing Loss Yes \_\_\_ No \_\_\_  
Seizures/Fainting Yes \_\_\_ No \_\_\_  
Headaches Yes \_\_\_ No \_\_\_  
Stroke Yes \_\_\_ No \_\_\_

**Cancer:**

Type of cancer: \_\_\_\_\_

**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 \_\_\_  
Fever/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 \_\_\_  
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: \_\_\_\_/\_\_\_\_/\_\_\_\_