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 ___

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 ___
Fevers/chills Yes ___ No ___
Night sweats Yes ___ No ___
Headaches Yes ___ No ___
Enlarged lymph nodes 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: ___/____/_____

Patient Signature: _____Date:__/___/__ Reviewed by: _____Date:__/___/__