

# DERMATOLOGY MEDICAL HISTORY

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referring Provider: \_\_\_\_\_ Phone # \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Pharmacy: \_\_\_\_\_ Phone # \_\_\_\_\_

Reason for your visit: \_\_\_\_\_

Are you allergic to any medications? (circle one, if YES please list) YES NO \_\_\_\_\_

Have you ever had a bad reaction to dental anesthesia? (circle one) 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\_\_\_

Empyema/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 (Hyper or Hypo) Yes\_\_\_ No\_\_\_

Kidney Yes\_\_\_ No\_\_\_

Dialysis Yes\_\_\_ No\_\_\_

**Cancer:**

Type of Cancer: \_\_\_\_\_

**Infectious Disease:**

HIV/AIDS Yes\_\_\_ No\_\_\_

HEP B Yes\_\_\_ No\_\_\_

HEP C Yes\_\_\_ No\_\_\_

List Major Surgeries and the year they were performed: \_\_\_\_\_

**Skin:**

History of Skin Cancer Yes\_\_\_ No\_\_\_ if yes type: \_\_\_\_\_

Family History of Skin Cancer Yes\_\_\_ No\_\_\_ if yes type: \_\_\_\_\_

History of a Skin Disease Yes\_\_\_ No\_\_\_ if yes type: \_\_\_\_\_

Problems with Healing Yes\_\_\_ No\_\_\_

Do you bleed easily? Yes\_\_\_ No\_\_\_

Develop rashes to bandages or Neosporin? Yes\_\_\_ No\_\_\_

**Women: Are you Pregnant?** Yes\_\_\_ No\_\_\_

**Are you Breastfeeding?** Yes\_\_\_ No\_\_\_

**Smoking Status:** (circle one please) Never Current Former

What is your occupation? \_\_\_\_\_ Hobbies? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

Pediatric Patients Only: Height \_\_\_\_\_ Weight \_\_\_\_\_