

# Dermatology Medical History

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Reason for Today's Visit: \_\_\_\_\_

Are you allergic to any medications? \_\_\_\_\_ If yes, Please list: \_\_\_\_\_

Have you ever had a negative reaction to Novacaine? \_\_\_\_\_

List all medications you are currently taking any medications? (Including over the counter, herbals, vitamins, and prescriptions)

## Skin:

When you are exposed to sun do you: ( ) tan ( ) tan and burn ( ) burn  
Have you ever had skin cancer? ( ) yes ( ) no If Yes, Where? \_\_\_\_\_  
Has anyone in your family had skin cancer? ( ) yes ( ) no If Yes, Who? \_\_\_\_\_  
Do you have a history of a skin disease? ( ) yes ( ) no If Yes, What? \_\_\_\_\_  
If yes, please list: \_\_\_\_\_

Do you develop skin rashes in reaction to ( ) medications ( ) food ( ) environment

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

<b>Lungs:</b>	<b>YES</b>	<b>NO</b>	<b>Other Systematic:</b>	<b>YES</b>	<b>NO</b>
Bronchitis	( )	( )	Diabetes	( )	( )
Emphysema	( )	( )	Excessive Thirst or hunger	( )	( )
Asthma	( )	( )	Thyroid	( )	( )
Chronic Cough	( )	( )	Kidney	( )	( )
Morning Cough	( )	( )	Bladder	( )	( )
Shortness of Breath	( )	( )	Frequency/Burning	( )	( )
Wheezing	( )	( )	Gastrointestinal	( )	( )
			Stomach disorders		
<b>Cardiovascular:</b>			Nausea	( )	( )
High blood pressure	( )	( )	Yeast infections	( )	( )
Chest Pain	( )	( )	Arthritis	( )	( )
Heart Attack	( )	( )	Artificial Joints	( )	( )
Heart Murmur	( )	( )	Convulsions or Seizures	( )	( )
Irregular Heart Beat	( )	( )	Fainting	( )	( )
Phlebitis	( )	( )			
Inflammation of vein	( )	( )			
Blood Clots	( )	( )			
Pacemaker	( )	( )			

Please list any other diseases or conditions: \_\_\_\_\_

Please list surgical procedures you have had in the last 6 months: \_\_\_\_\_

## Social History:

Do you drink alcohol? \_\_\_\_\_ drinks per day  
Do you use IV drugs? If yes, what? \_\_\_\_\_ How Much? \_\_\_\_\_  
Do you smoke? If yes, how much? \_\_\_\_\_ per day  
Have you had or have you been exposed to HIV (AIDS)? \_\_\_\_\_

Please answer the following:

Do you bleed easily? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_  
What is your occupation? \_\_\_\_\_ What are your hobbies? \_\_\_\_\_  
How did you hear about our practice: ( ) friend ( ) phone book ( ) newspaper ( ) movie theatre ( ) radio ( ) TV

Please Name the Physician who referred you here today: \_\_\_\_\_ Phone: \_\_\_\_\_

Practice Name: \_\_\_\_\_ Address: \_\_\_\_\_