Dermatology Medical History

Patient:____________________ **Date:** ____________

Reason for today's visit: ____________________

Are you allergic to any medications? ☐ Yes ☐ No If yes, list below:

1. ________ **2.** ________ **3.** ________

Have you ever had dental anesthesia (Novocaine)? ☐ Yes ☐ No **Any bad reaction?** ☐ Yes ☐ No

List all current medications you are taking (including prescriptions, over-the-counter meds, vitamins, & 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:	**YES**	**NO**
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐
Cardiovascular:		
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Inflammation of vein	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐

Other Systemic:	**YES**	**NO**
Diabetes	☐	☐
Excessive thirst/hunger	☐	☐
Amputation	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Dialysis	☐	☐
Bladder	☐	☐
Frequency/Burning	☐	☐
Gastrointestinal		
Stomach absorptive disorder	☐	☐
Nausea, vomiting, diarrhea when taking antibiotics	☐	☐
Yeast infection when taking	☐	☐
antibiotics	☐	☐
Arthritis/Joint Deformity	☐	☐
Arthralgia	☐	☐
Limited motion	☐	☐
Artificial joint	☐	☐
Convulsions/Epilepsy/Seizures	☐	☐
Fainting	☐	☐

Social History: **Do you:**	**YES**	**NO**
Drink alcohol?	☐	☐
If YES, _______ drinks/day		
Use IV drugs?	☐	☐
If YES, what? ________		
How often? ________		
Smoke?	☐	☐
If YES, how much? ________		
Have you had or have you been exposed to HIV (AIDS)?	☐	☐

List any other diseases or conditions: ____________________

List surgical procedures you have had in the last 6 months: ____________________

Skin: Have you ever had a skin cancer? ☐ Yes ☐ No If YES, (kind) ____________
Has anyone in your family had a skin cancer? ☐ Yes ☐ No If YES, who? ____________
Do you have a history of any specific skin diseases? ☐ Yes ☐ No If YES, ____________

Do You:

Y	N	
☐	☐	Have trouble healing?
☐	☐	Bleed excessively?
☐	☐	Have a tendency to form hypertrophic scars & keloids?
☐	☐	Develop contact dermatitis to antibiotic ointments?
☐	☐	Develop contact dermatitis to bandages & tapes?
☐	☐	Have enlarged lymph nodes?
☐	☐	Are you immunosuppressed?

Y	N	
☐	☐	Have difficulty with systemic antibiotics?
☐ Nausea	☐ Persistent yeast infections	☐ Vomiting
☐	☐	Have a prosthetic hip replacement?
☐	☐	Have a pacemaker/defibrillator?
☐	☐	Take aspirin/anticoagulant daily?
☐	☐	Have a mitral valve prolapse?
☐ Other ____________		

Please answer the following questions:

(Women) Are you pregnant? ☐ Yes ☐ No Due Date: ____/____/____

What is your occupation? ____________ Hobbies? ____________

Completed by: ☐ Patient
☐ Medical Assistant

____________ Patient Signature ____________ Date

________ Initials ____________ Reviewed By ____________ Date