

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)

Lungs:	YES	NO	Other Systematic:	YES	NO
Bronchitis	()	()	Diabetes	()	()
Emphysema	()	()	Excessive Thirst or hunger	()	()
Asthma	()	()	Thyroid	()	()
Chronic Cough	()	()	Kidney	()	()
Morning Cough	()	()	Bladder	()	()
Shortness of Breath	()	()	Frequency/Burning	()	()
Wheezing	()	()	Gastrointestinal	()	()
			Stomach disorders		
Cardiovascular:			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: _____