

Dermatology Medical History

Patient: _____ Date of Birth: ____/____/____ Today's Date: ____/____/____

Reason for today's visit: _____

Are you allergic to any medications? YES NO If yes, list below:

1. _____ 2. _____

Have you ever had dental anesthesia (Lidocaine)? YES NO Any bad reaction? YES NO

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	Yes	No	Other Systemic:	Yes	No
Bronchitis			Diabetes		
Emphysema			Excessive thirst/hunger		
Asthma			Amputation		
Chronic Cough			Thyroid		
Morning Cough			Kidney		
Shortness of Breath			Dialysis		
Wheezing			Bladder		
Cardiovascular:			Frequency/burning		
High Blood Pressure			Gastrointestinal		
Chest Pain			Stomach absorptive disorder		
Heart Attack			Nausea, vomiting, diarrhea		
Heart Murmur			when taking antibiotics		
Irregular Heartbeat			Hepatitis		
Phlebitis			Yeast infection when		
Inflammation of vein			taking antibiotics		
Blood Clots			Arthritis/Joint Deformity		
Pacemaker			Arthralgia		
Mental Health Disorders:			Limited Motion		
Alzheimer's			Artificial Joint		
			Convulsions, Epilepsy, Seizures		
			Fainting		

List any other diseases or conditions: _____

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

Skin: Have you ever had skin cancer? YES NO

Has anyone in your family had skin cancer? YES NO

Do you have a history of any specific skin diseases? 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 skin rashes in reaction to: Medications Food Environment Bandages Topical Neosporin
 Other _____

Social History:

Do you drink alcohol? YES NO If Yes _____ drinks per day

Do you use IV drugs? YES NO If Yes _____ what/how often

Do you smoke? YES NO If Yes _____ how much

Have you had or have you been exposed to HIV (AIDS)? YES NO

(Women) Are you pregnant? YES NO Due Date: ____/____/____

Family History of Medical Illnesses: _____

What is your occupation? _____ Hobbies? _____