Dermatology Medical History

Patient: _____ Date of Birth::___/___/___ Referred by:_____
Reason for today's visit:
_____

Are you allergic to any medications? ❑ YES ❑ NO If yes, list below along with reaction:
1. _____ 2. _____

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

List all medications you are currently taking (including prescription and, over-the-counter medications)
1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Do you or your family have now, or have you ever had diseases or conditions of:

Pulmonary:	**Self**	**Family (list who)**
Emphysema	❑	❑_____
Asthma	❑	❑_____
Chronic Cough	❑	❑_____
Shortness of Breath	❑	❑_____
Wheezing	❑	❑_____
Cardiovascular:		
High Blood Pressure	❑	❑_____
High Cholesterol	❑	❑_____
Heart Attack	❑	❑_____
Heart Murmur	❑	❑_____
Irregular Heartbeat	❑	❑_____
Phlebitis	❑	❑_____
Pacemaker	❑	❑_____
Psychiatric		
Depression	❑	❑_____
Anxiety	❑	❑_____

Other Systemic:	**Self**	**Family (list who)**
Diabetes	❑	❑_____
Thyroid disease	❑	❑_____
Kidney disease	❑	❑_____
Dialysis	❑	❑_____
Bladder/prostate problems	❑	❑_____
Seasonal allergies	❑	❑_____
Gastrointestinal		
Hepatitis A/B/C	❑	❑_____
Crohn's disease	❑	❑_____
Ulcerative colitis	❑	❑_____
Reflux	❑	❑_____
Arthritis/Joint Deformity		
Arthritis:type:_____	❑	❑_____
Artificial joint	❑	❑_____
Neurologic		
Seizure disorder	❑	❑_____
Stroke	❑	❑_____

List any other diseases/cancer_____
List prior surgical procedures_____
Please circle if you are currently having any of the following symptoms: **GENERAL:** fevers/chills/fatigue/weight loss/excessive thirst or hunger **EYES/EARS:** dry eyes/vision or hearing loss /dry mouth/mouth sores
RESPIRATORY: cough/shortness of breath/wheezing **CARDIAC:** Chest pain/irregular heartbeat/legs swelling
GI: nausea/vomiting/diarrhea/reflux **GU:** urinary burning/frequency/incontinence
JOINTS: joint pain/swelling/muscle pain **NEURO/PSYCH:** weakness/headaches/depression/anxiety

Skin: Have you ever had skin cancer? ❑ YES ❑ NO
❑**Basal cell carcinoma** ❑ **Squamous cell carcinoma** ❑**Melanoma** Sites_____
Has anyone in your family had skin cancer? ❑ YES ❑ NO If yes_____
Do you have a history of any specific skin diseases? ❑ YES ❑ NO If yes_____
Do you develop keloids (scars) after surgery ❑ YES ❑ NO
Do you develop skin rashes to: ❑Medications ❑Food ❑Bandages ❑Neosporin ❑ Other_____

Social Do you drink alcohol?❑ YES ❑ NO _____per day Do you smoke?❑YES❑ NO_____per day
Date of last flu shot Date:___/___/___ Date of last pneumonia shot (if over age 65_ Date:___/___/___
(Women) Are you pregnant? ❑ YES❑ NO Due Date:___/___/___Are you planning pregnancy soon? ❑ YES ❑ NO
What is/was your occupation? _____ ❑ retired
What are you hobbies? _____ What is your preferred pharmacy?_____
Completed by:_____ ___/___/___