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 (Novocaine)? ☐ 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**
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐

Cardiovascular:	**YES**	**NO**
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 or Seizure, 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: ___/___/___

What is your occupation? _____ Hobbies? _____

Completed by: ☐ Patient ☐ Med. Assist _____ Initials

_____	___/___/___	___/___/___	____
Signed by Patient	Date	Updated	Init
_____	___/___/___	___/___/___	___
Reviewed by	Date	Updated	Init