PATIENT NAME:____

DERMATOLOGY MEDICAL HISTORY

What is the reason for your visit today? ____

How did you hear of us? ☐Friend ☐Family ☐Ad ☐Yellow Pages ☐Other ☐Physician (name) ______________________

Are you allergic to any medications? ☐ YES ☐ NO If yes, please list: ______________________________________

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

____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

Do you drink alcohol?	☐ YES	☐ NO	If YES, what? ____________ How often? _________
Have you ever used recreational IV drugs?	☐ YES	☐ NO	
Do you smoke?	☐ YES	☐ NO	If YES, how much? ______packs/day
Do you have a history of slow healing or keloids?	☐ YES	☐ NO	
Have you ever had skin cancer?	☐ YES	☐ NO	If YES, what kind? __________________________
Has anyone in your family had skin cancer?	☐ YES	☐ NO	If YES, who & what kind? ____________________
Do you have any history of skin problems?	☐ YES	☐ NO	If YES, what kind? _________________________
Have you ever been exposed to HIV?	☐ YES	☐ NO	
Do you have any artificial joints?	☐ YES	☐ NO	
Do you take antibiotics before dental work?	☐ YES	☐ NO	
Have you ever had dental anesthesia?	☐ YES	☐ NO	If yes, any bad reaction? ______________________
Do you bleed easily?	☐ YES	☐ NO	
(**WOMEN**) Are you pregnant?	☐ YES	☐ NO	Due Date: ____________
Are you breast feeding?	☐ YES	☐ NO	

Do you have now, or have you ever had (Please check all that apply):

	Y	N		Y	N		Y	N
AIDS/HIV	☐	☐	Chronic cough	☐	☐	Kidney disease	☐	☐
Allergy	☐	☐	Diabetes	☐	☐	Liver disease	☐	☐
Family allergy history	☐	☐	Emphysema	☐	☐	Lupus	☐	☐
Allergy treatment	☐	☐	Epilepsy	☐	☐	Measles	☐	☐
Anemia	☐	☐	Fainting	☐	☐	Migraines	☐	☐
Arthritis	☐	☐	Glaucoma	☐	☐	Mononucleosis	☐	☐
Asthma	☐	☐	Hay Fever	☐	☐	Multiple sclerosis	☐	☐
Bladder problems	☐	☐	Heart Attack	☐	☐	Pacemaker	☐	☐
Bleeding disorder	☐	☐	Heart disease	☐	☐	Phlebitis	☐	☐
Bowel problems	☐	☐	Heart murmur	☐	☐	Psychiatric care	☐	☐
Bronchitis	☐	☐	High blood pressure	☐	☐	Rheumatic fever	☐	☐
Chemical dependency	☐	☐	Hepatitis	☐	☐	Scarlet fever	☐	☐
Chest pain	☐	☐	Herpes/cold sores	☐	☐	Seizures	☐	☐
Chicken pox	☐	☐	Irregular heart beat	☐	☐	Stomach problems	☐	☐

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Stroke	☐	☐	Typhoid fever	☐	☐	Venereal disease	☐	☐
Thyroid problems	☐	☐	Ulcers	☐	☐			
Tuberculosis	☐	☐	Vaginal infections	☐	☐			

Do you have any history of cancer? ☐YES ☐NO If YES, what kind? ____

Do you develop skin rashes to: ☐Medications ☐Food ☐Environment? If so, what? ____________________________

Do you have any medical conditions which were not listed above (please list)? ________________________________

Please list any surgeries you have had in the past:

____

____

What outdoor activities do you do (check all that apply)?

☐Golf	☐Gardening	☐Other sports ________________
☐Tennis	☐Biking	
☐Swimming	☐Walking	
☐Fishing	☐Boating	

What is your occupation? ___________________________________

____ _____________________________

Patient's Signature Date

____ _____________________________

Parent or Guardian Date