DERMATOLOGY MEDICAL HISTORY

Name ____

What is the reason for your visit today? ____

Were you referred by a physician? If yes, whom ____

Who is your Primary Care Physician? ____

Were you referred to a general dermatologist or Dr Kongsiri specifically?____

What Pharmacy do you use? ____

What is the Pharmacy's phone number and address? ____

Allergies / Current Medications

Are you allergic to Latex? YES NO
Are you allergic to Lidocaine? YES NO
Any vitamins / minerals – check all that you are taking:

- None
- Calcium supplements
- Chinese herbs
- Herbal supplements
- Multi-vitamin
- Vitamin B
- Vitamin C
- Vitamin D
- Vitamin E
- Vitamin K

Do you have any drug allergies? ☐ YES ☐ NO

If yes, please list:

____

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

___________________________________ ____ _______________________________

___________________________________ ____ _______________________________

Past Medical History

Have you had any previous hospitalizations? If yes, explain ____

____

Please select what best describes your current general health:

Good General Health	Fevers
Recent Weight Gain	Headaches
Recent Weight Loss	Pregnant (Yes/No)
Poor Nutrition	Chronic Fatigue

DERMATOLOGY MEDICAL HISTORY

Complete Past Medical History – Please Circle any that Apply:

Abnormal clotting
Abnormal menstruation
Acne
Actinic keratosis
Addison's
Alopecia
Anemia
Anticoagulation
Anxiety
Arrhythmias
Arthritis
Back pain
Basal Cell Carcinoma
Where ______________
Bipolar disorder
Bleeding ulcers
Currently breast feeding
Breast mass (left, right)
Coronary artery disease
Cancer:
Breast
Colon
Skin
Liver
Lung
CHE
Chronic edema
Chronic Fatigue
Cirrhosis
Constipation
Contact usage
Chronic obstruct. pulmonary disease
Cushings
Depression
Dermatitis
Dermatophytosis
Diabetes (diet controlled)
Diabetes (insulin depend.)
Diabetes (oral medication)
Difficult extubation
Difficult intubation
Difficulty walking
Dry eyes
Deep vein thrombosis
Easy bleeding
Eczema
Emphysema
Fibromyalgia
Gall stones
Genital warts
GERD
Hair loss
Hearing loss
Heart attack
Hemophilia
Hepatitis A
Hepatitis B
Hepatitis C
Herpes zoster
Herpes Simplex
High blood pressure
HIV
HSV I
HSV II
Hypercholesterol
Hyperthyroid
Hyperthyroidism
Hypothyroid
Incontinence
Intertriginous rashes
Irritable bowel
Jaundice
Keloids
Kidney stones
Lupus
Malignant hyperthermia
Malignant melanoma
Where ________________
Migraines
Mitral valve prolapsed
Neck pain
Nipple discharge (left, right)
Onychomycosis
Oral herpes
Pacemaker
Polycystic ovary syndrome
Pulmonary embolism
Pilonidal cyst
Postop N/V
Psoriasis
Peripheral vascular disease
Pyelonephritis
Rheumatoid Arthritis
Recurrent UTI
Renal failure
Renal insufficiency
Rosacea
Squamous Cell Carcinoma
Where __________________
Seasonal allergies
Shoulder grooving
Shoulder pain
Slow healing
Skin problems
Snoring/apnea
TB
Telangiectasia
Ulcers
Urethral structure
Varicella
Varicose veins
Venous insufficiency
Vision loss
Warts

Have you ever been exposed to HIV? YES NO
Explain ____

Do you have any artificial joints? YES NO
Explain ____

Do you take antibiotics before dental work? YES NO
Explain ____

DERMATOLOGY MEDICAL HISTORY

Have you ever had dental anesthesia? YES NO
Explain ____

Do you develop skin rashes to food? YES NO
Explain ____

Do you develop skin rashes to medications? YES NO
Explain ____

Do you develop skin rashes from environmental factors? YES NO
Explain ____

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

____

Past Surgical History – Please Circle all that Apply:

No Past Surgical History

FACIAL COSMETIC SURGERY
- Hair transplant
- Browlift
- Upper blepharoplasty
- Lower blepharoplasty
- Facelift
- Midface lift

HEENT SURGERY
- Cleft lip
- Cleft palate
- Intracranial surgery
- Facial fracture repair
- Lasik surgery
- RK surgery
- Ptosis correction
- Strabismus correction
- Otoplasty
- Rhinoplasty
- Septoplasty
- Thyroidectomy
- Turbinate surgery

Tonsillectomy

BREAST SURGERY
- Breast augmentation (saline, silicone)
- Breast reduction
- Mastopexy
- Mastectomy (right, left)
- Reconstruction (implant)
- Reconstruction (TRAM)
- Reconstruction (Lat Dorsi)

TRUNK SURGERY
- Abdominoplasty
- Back surgery
- Rectus placation
- Liposuction (abdomen, chest, flanks, hips)

ABDOMINAL SURGERY
- Appendectomy
- Cholecystectomy
- Gastric bypass
- Gastric banding
- Spleenectomy
- Bowel resection
- Hernia repair

PELVIC SURGERY
- Hysterectomy
- BSO
- C-section
- Female genital surgery
- Male genital surgery

EXTREMITY SURGERY
- Hand surgery
- Carpal tunnel release
- Joint replacement
- Brachioplasty
- Liposuction (arm, medial thigh, lateral thigh, calves)
- Buttock lift
- Body lift
- Medial thigh lift
- Varicose vein surgery

Social History

Do you smoke? YES NO

If YES, how much? ______ # packs/day
I did, but I quit _______ quitting date

DERMATOLOGY MEDICAL HISTORY

Alcohol usage:

Denies   Weekly 1-2   Weekly 3 or more   Daily   Alcoholic

Current or Past Tanning Bed usage:

Denies   Weekly   Monthly   Past Use

Do you use sunscreen?

Daily   always if sunny   sometimes if sunny   rarely/never

What is your occupation?

____

Birth Control Method (if applicable) ____________________________________

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

- Biking
- Boating
- Fishing
- Gardening
- Golf
- Running
- Swimming
- Tennis
- Walking
- Other sports __________________

Height:________________   Approximate Weight:_____________

Family History

	Mark YES (if no, do not mark)	Family Member (mother, father, brother, sister, etc)	Notes
Allergies			
Arthritis			
Asthma			
Cancer			
Diabetes			
Eczema			
Heart disease			
High blood pressure			
Lung disease			
Psoriasis			
Tuberculosis			

Patient’s Signature ___________________________________   Date __________________________

Parent or Guardian ___________________________________   Date __________________________