

Dermatology Medical History

Patient: _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? YES NO If yes, list:
 1. _____ 2. _____

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

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

	YES	NO		YES	NO
Lungs:			Other Systemic:		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal		
			Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:			Nausea, vomiting, diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection when		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>

Skin:

When you are exposed to sun do you: Tan only Tan and burn Burn
 Have you ever had skin cancer? YES NO
 Has anyone in your family had skin cancer? YES NO If YES, Who? _____
 Do you have a history of any specific skin diseases? YES NO
 If yes, please list: _____
 Do you develop skin rashes in reaction to Medications Food Environment? _____

List any other diseases or conditions: _____

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

Social History:

Do you drink alcohol? YES NO If YES _____ drinks per day
 Do you use IV drugs? YES NO If YES, what? _____ How much? _____
 Do you smoke? YES NO If YES, how much: _____
 Have you had or have you been exposed to HIV (AIDS) ? YES NO

Please answer the following questions:

- A. Do you bleed easily? YES NO
- B. (Women) Are you pregnant? YES NO Due Date: _____
- C. What is your occupation? _____
- D. What are your hobbies? _____

Completed by: Patient
 Medical Assistant _____
Initials

 Signed by Patient Date

 Reviewed by Date