DERMATOLOGY MEDICAL HISTORY

Patient Name____ Date___/___/___
Reason for today's visit____

Please list drug allergies____

List all medications including aspirin, over the counter meds, vitamins, and herbs:

____

____

Do you now, or have you ever had any of the following conditions: (Check Yes or No)

	YES	NO
Lungs:		
Asthma	☐	☐
Emphysema	☐	☐
Bronchitis	☐	☐
Shortness of breath	☐	☐
Cardiovascular:		
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heart Beat	☐	☐
Phlebitis	☐	☐
Blood Clots	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Bypass surgery	☐	☐
Gastrointestinal:		
Liver Disease	☐	☐
Hepatitis	☐	☐
Ulcers	☐	☐

	YES	NO
Neurologic:		
Seizures	☐	☐
Stroke	☐	☐
Easy fainting	☐	☐
Migraines	☐	☐
Allergy:		
Hay fever	☐	☐
Sinus allergies	☐	☐
Eczema	☐	☐
Other Systemic:		
Diabetes	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Arthritis	☐	☐
Artificial joint(s)	☐	☐
Cancer	☐	☐
HIV/AIDS	☐	☐
Easy bleeding	☐	☐
History of transfusion	☐	☐

List any other medical problems:____
List any surgical procedures:____

Women only: Are you pregnant? ☐YES ☐NO Nursing? ☐YES ☐NO

Skin:

Have you ever had skin cancer? ☐YES ☐NO
Has anyone in your family had skin cancer? ☐YES ☐NO
Any history of skin disease? ☐YES ☐NO
Any history of keloid scarring? ☐YES ☐NO

Social History:

Do you drink alcohol? ☐YES ☐NO Do you smoke? ☐YES ☐NO
Occupation?_________________________ Hobbies?______________________________

Signature of patient_______________________ **Reviewed by**___________________________