

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. _____ 3. _____

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
Shortness of Breath
Wheezing

Other Systemic

YES NO

Diabetes
Thyroid
Kidney
Dialysis
Gastrointestinal
Stomach absorptive disorder
Nausea, vomiting, diarrhea
when taking antibiotics
Yeast infection when
taking antibiotics
Joint
Joint pain
Limited motion
Artificial joint
Epilepsy or Seizures
Fainting
Transplant

Cardiovascular:

High Blood Pressure
Chest Pain
Heart Attack
Heart Murmur
Irregular Heartbeat
Phlebitis
Inflammation of vein
Blood clots

Pacemaker

Psychiatric

Depression
OCD
manic depressive disorder
ADD
anxiety

List any medications: _____

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 unusual scars after surgery? YES NO
Do you bleed easily? YES NO
Do you develop skin rashes in reaction to: Medications Food Environment
Other _____

Social History:

Do you drink alcohol? YES NO If YES _____ drinks per day
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? _____

Completed by: _____
Signature

Patient
Other