

Dermatology Medical History

Patient: _____ Date: _____

Occupation: _____

Race: _____ Ethnicity: _____ Hobbies: _____

Have you ever had skin cancer? Yes or No

If yes, what type(s)? _____

Has anyone in your family had skin cancer? Yes or No

If yes, who and what type(s)? _____

When Exposed to the sun do you: Tan only Tan and burn Burn

Do you have a history of any other skin diseases? Yes or No

If yes, please list: _____

Do you have now or has a member of your family ever had diseases or conditions of:

	<u>You</u>		<u>Family</u>			<u>You</u>		<u>Family</u>	
	Yes	or No	Yes	or No		Yes	or No	Yes	or No
Lungs:					Other systemic:				
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal or stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Nausea, vomiting, diarrhea when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:					Yeast infection when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/joint deformity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Limited joint motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Circle any of the following medical conditions you have now or have had in the past:

- | | | | |
|------------------|---------------------|--------------------|-------------------|
| Mumps | Tonsillitis | Cellulitis | MRSA |
| Measles | Gout | Stomach Ulcers | Anxiety |
| Chicken pox | Bladder Infection | Cancer | Bi-Polar Disorder |
| Scarlet fever | Glaucoma | Stroke | Depression |
| Venereal disease | Bleeding Disease | Blood Transfusions | Mood Disorder |
| Tuberculosis | Recent Strep Throat | High Cholesterol | Other: _____ |
| Whooping Cough | Pneumonia | Hepatitis | _____ |

Do you drink alcohol? Yes or No If yes, socially or daily? _____

Do you smoke? Yes or No If yes, how much? _____

Do you use IV drugs? Yes or No If yes, what and how much? _____

Have you ever been exposed to HIV/AIDS? Yes or No

Have you ever had surgery? Yes or No

If yes, were any of them within the last 12 months? Yes or No

*Please list below all surgeries (major or minor) that you have had and the dates they were performed.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications and Allergies:

List all medications that you are currently taking:

(Please include prescriptions, over-the-counter medications, vitamins, and herbals)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any medications? Yes or No

If yes, please list: _____

Do you develop skin rashes in reaction to any of the following? Food Environment Other

If checked, please explain: _____

Have you ever had dental anesthesia? Yes or No

Any bad reaction? Yes or No

If yes, please explain: _____

Do you bleed easily? Yes or No

(Women) Are you pregnant? Yes or No Due Date: _____

Completed by: Patient Medical Assistant _____
(Initials)

Signed by patient Date

Reviewed by Date