NEW RIVER DERMATOLOGY PLC

Dermatology Medical History

Patient: _____ Date: _____

Occupation: _____

Race: _____ Ethnicity: _____ Hobbies: _____

Have you ever had skin cancer? ☐ Yes ☐ No

If yes, what type(s)? _____

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

If yes, please list: _____

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

	You		Family	
Lungs:	**Yes**	**No**	**Yes**	**No**
Bronchitis	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Chronic Cough	☐	☐	☐	☐
Morning Cough	☐	☐	☐	☐
Shortness of breath	☐	☐	☐	☐
Wheezing	☐	☐	☐	☐
Cardiovascular:				
Heart Disease	☐	☐	☐	☐
Heart Murmur	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Chest Pain	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐
Irregular Heartbeat	☐	☐	☐	☐
Inflammation of vein	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐
Pacemaker	☐	☐	☐	☐

	You		Family	
Other Systemic:	**Yes**	**No**	**Yes**	**No**
Diabetes	☐	☐	☐	☐
Excessive thirst/hunger	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐
Kidney	☐	☐	☐	☐
Bladder	☐	☐	☐	☐
Urinary frequency/burning	☐	☐	☐	☐
Gastrointestinal/stomach absorptive disorder	☐	☐	☐	☐
Nausea, vomiting, diarrhea when taking antibiotics	☐	☐	☐	☐
Yeast infection when taking antibiotics	☐	☐	☐	☐
Arthritis/joint deformity	☐	☐	☐	☐
Limited joint motion	☐	☐	☐	☐
Artificial joint(s)	☐	☐	☐	☐
Convulsions, epilepsy/ seizures	☐	☐	☐	☐
Fainting	☐	☐	☐	☐

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

Mumps
Measles
Chicken Pox
Scarlet Fever
Venereal Disease
Tuberculosis
Whooping Cough

Tonsillitis
Gout
Bladder Infection
Glaucoma
Bleeding Disease
Recent Strep Throat
Pneumonia

Cellulitis
Stomach Ulcers
Cancer
Stroke
Blood Transfusions
High Cholesterol
Hepatitis

MRSA
Anxiety
Bi-Polar Disorder
Depression
Mood Disorder
Other: _____

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

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

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

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

Have you ever had surgery? ☐ Yes ☐ No

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

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

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medication 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 ☐ No

If yes, please list: _____

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

If checked, please explain: _____

Have you ever had dental anesthesia? ☐ Yes ☐ No

Any bad reaction? ☐ Yes ☐ No

If yes, please explain: _____

Do you bleed easily? ☐ Yes ☐ No

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

Completed by: ☐ Patient ☐ Medical Assistant (Initials): _____

_____ _____

Signed by Patient **Date** **Reviewed by** **Date**