Dermatology Medical History

Name: ________________________________ Age:_____ DOB::___/___/___ Today's Date: ___/___/___

Reason for today's visit: ________________________________

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

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

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):
1. ____________ 3. ____________ 5. ____________
2. ____________ 4. ____________ 6. ____________

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

Condition			Condition		
Anemia	❑ Y	❑ N	Difficulty Breathing	❑ Y	❑ N
High Blood Pressure	❑ Y	❑ N	Emphysema/Bronchitis	❑ Y	❑ N
Heart Disease or Chest Pain	❑ Y	❑ N	Asthma/ Hay fever	❑ Y	❑ N
Heart Attack	❑ Y	❑ N	Tuberculosis	❑ Y	❑ N
Heart Murmur	❑ Y	❑ N	Fainting Spells or Dizziness	❑ Y	❑ N
Irregular Heart Beat	❑ Y	❑ N	Cancer, type______________	❑ Y	❑ N
Pacemaker	❑ Y	❑ N	Thyroid Disease	❑ Y	❑ N
Artificial Heart Valve	❑ Y	❑ N	Diabetes	❑ Y	❑ N
Mitral Valve Prolapse	❑ Y	❑ N	Kidney Disease	❑ Y	❑ N
Blood Transfusion	❑ Y	❑ N	Gastrointestinal Problems	❑ Y	❑ N
Bleeding disorder or tendency	❑ Y	❑ N	Hepatitis or Yellow Jaundice	❑ Y	❑ N
Blood Clots	❑ Y	❑ N	Arthritis	❑ Y	❑ N
Aids or HIV Positive	❑ Y	❑ N	Artificial Joints (hip, knee,etc)	❑ Y	❑ N
Stroke	❑ Y	❑ N	Epilepsy/Seizures	❑ Y	❑ N
Ears, Nose, Throat Problems	❑ Y	❑ N	Psychological Problems	❑ Y	❑ N
Glaucoma or Eye Problems	❑ Y	❑ N	Neurological Problems	❑ Y	❑ N
Preskin Cancer	❑ Y	❑ N	Abnormal Lymph Nodes	❑ Y	❑ N
Psoriasis	❑ Y	❑ N	Eczema	❑ Y	❑ N
Lupus	❑ Y	❑ N	Keloids	❑ Y	❑ N
Raynaud's	❑ Y	❑ N	Been on Isotretinoin	❑ Y	❑ N
X-Ray Treatment for Acne	❑ Y	❑ N	Radiation Treatment	❑ Y	❑ N
Skin Cancer	❑ Y	❑ N			

What Type? ❑ Basel Cell ❑ Squamous Cell ❑ Melanoma

List any other diseases or conditions: ________________________________

List surgical procedures you have had: ________________________________

List cosmetic procedures you have had: ________________________________

Social History:
Do you drink alcohol? ❑ YES ❑ NO If YES _________ drinks per day
Do you use IV drugs? ❑ YES ❑ NO If YES, what? ____________ How often? ____________
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? ________________________________
Hobbies? ________________________________

Completed by: ❑ Patient ________________________ ___/___/___
❑ Med. Assist ______ Signed by Patient Date
Initials