Dermatology Medical History

Patient: ______________________________ Date of Birth: ____/____/____ Today's Date: ____/____/____

Reason for visit today: ____

Are you allergic to any medications? ☐ YES ☐ NO If yes, list below:

1. ____________________ **2.** ____________________ **3.** ____________________

Have you ever had dental anesthesia (Novocaine)? ☐ YES ☐ NO Any adverse reaction? ☐ YES ☐ NO
Do you have a pacemaker or other implantable electrical device? ☐ YES ☐ NO

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, **dosage** and herbals):

1. ____________________ 2. ____________________ 3. ____________________
4. ____________________ 5. ____________________ 6. ____________________

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	☐	☐
Morning Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐
Cardiovascular:		
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Inflammation of vein	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐

Other Systemic:	**YES**	**NO**
Diabetes	☐	☐
Excessive thirst/hunger	☐	☐
Bleeding Tendency	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Dialysis	☐	☐
Bladder	☐	☐
Frequency/burning	☐	☐
Gastrointestinal		
Stomach absorptive disorder	☐	☐
Nausea, vomiting, diarrhea when taking antibiotics	☐	☐
Yeast infection when taking antibiotics	☐	☐
Arthritis/Joint Deformity	☐	☐
Arthralgia	☐	☐
Limited motion	☐	☐
Artificial joint	☐	☐
Convulsions, Epilepsy or Seizure, Fainting	☐	☐

List any other diseases or conditions: ______________________________
List surgical procedures you have had in the last 10 years: ______________________________
Have you had any previous hospitalizations? Y/ N______________________________

Skin:
Have you ever had skin cancer? ☐ YES ☐ NO If YES, ______________
Has anyone in your family had skin cancer? ☐ YES ☐ NO If YES, ______________
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 keloids (scars) after surgery ☐ YES ☐ NO
Do you develop skin rashes in reaction to: ☐ Medications ☐ Food ☐ Environment ☐ Bandages ☐ Topical ☐ Neosporin ☐ Other ______________________________

Please answer the following:

Do you drink alcohol? ☐ YES ☐ NO **If YES** _____ drinks/day Do you smoke? ☐ YES ☐ NO **If YES** _____ packs/day

Do you have or have you been exposed to HIV (AIDS)? ☐ YES ☐ NO

(Women) Are you pregnant? ☐ YES ☐ NO Due Date: _____/_____/_____ Are you breastfeeding? ☐ YES ☐ NO

Other Skin Care Interests (please check all that apply):

☐Acne	☐Chemical Peels	☐Liver/Age Spots	☐Hair Loss
☐Sun Damage	☐Laser Treatments	☐Latisse	☐Hair Removal
☐Excess Sweating	☐Skin Care Advice	☐Obagi	☐Other:____________
☐Sunscreen Advice	☐Skin Care Products	☐Botox	____________
☐Birthmarks/Moles	☐Skin Rejuvenation	☐Juvederm	

Primary Care Physician: ______________________ Pharmacy: ____________________Phone:__________

Patient or Guardian Signature: ______________________________ **Date**: _____/_____/_____