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 **or attach copy**:

1. _____ 2. _____

Have you ever had dental anesthesia (Novocain)? □ YES □ NO Any bad reaction? □ YES □ NO

Do you take an antibiotic prior to dental cleaning? □ YES □ NO

Do you take a blood thinner? □ YES □ NO If YES, which one? _____

Do you have a pacemaker/defibrillator/stimulator/other electrical device in your body? □ YES □ NO

List **or attach copy** of all medications you are currently taking (including prescriptions, birth control, over-the-counter, vitamins, supplements and herbals):

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please CIRCLE if yes)

Asthma	Diabetes	Arthritis
Shortness of Breath	Amputation	Artificial Joint
High Blood Pressure	Thyroid Disease	Polycystic Ovarian Syndrome
Chest Pain	Abnormal Kidney Function	Seizures
Heart Attack	Dialysis	Immune Suppressed
Irregular Heartbeat	Stomach Absorptive Disorder	Glaucoma
Inflammation of a Vein	Stomach Ulcer	Liver Disease
Blood Clot	Bleeding Disorder	Depression/Anxiety
Artificial Heart Valve	Yeast infection while taking antibiotics	Dementia

Are you currently experiencing: (Please CIRCLE if yes)

Fever/Chills	Weakness/Vision Changes	Easy Bleeding/Bruising
Cough/Shortness of Breath	Sun Sensitivity	Burning with Urination
Nausea/Vomiting/Diarrhea	Joint Pain	Swollen Glands
Chest Pain	Bleeding/Painful/Itching/Changing Skin Lesions	Nose Bleeds
Headache	Rash	

List any other diseases or conditions: _____

List surgical procedures you have had within the last 6 months: _____

Have you ever had skin cancer? □ YES □ NO

If YES please check type: □ Actinic Keratosis (pre-cancer) □ Basal Cell □ Squamous Cell □ Melanoma

□ Don't Know □ Other _____

Has anyone in your family had skin cancer? □ YES □ NO

If YES please check type: □ Actinic Keratosis (pre-cancer) □ Basal Cell □ Squamous Cell □ Melanoma

□ Don't Know □ Other _____

Do you have a history of any specific skin diseases? □ YES □ NO

If YES please check type: □ Eczema □ Psoriasis □ Other_____

Do you have a history of other types of cancer (besides skin cancer)? □ YES □ NO

If YES, what type?_____

Do you develop keloids (thick scars) after surgery □ YES □ NO

Do you develop skin rashes in reaction to □ Medications □ Food □ Environment □ Bandages □ Topical Polysporin

□ Other _____

Do you drink alcohol? □ YES □ NO If YES please circle: 1 per week / 1-6 per week / >6 per week

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 Hepatitis C? □ YES □ NO

Have you had the flu vaccine in the last 12 months? □ YES □ NO If YES, when: _____ (Month/Year)

Have you ever had the pneumonia vaccine? □ YES □ NO

(Women) Are you pregnant? □ YES □ NO Due Date: ___/___/___ Breastfeeding? □ YES □ NO

What is your occupation? _____ Hobbies? _____

Completed by: □ Patient _____ Date: ____/____/____

□ Med. Assist _____ Signed by Patient

Initials _____ Date: ____/____/____

Reviewed by