

Dermatology Medical History

Patient : _____ Age _____ Date of Birth _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? YES NO If yes, what _____

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

What type of reaction? _____

List all medications you currently take (include prescriptions, over-the-counter, vitamins, and herbals):

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

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

Lungs:	Yes	No	Endocrine:	Yes	No
Bronchitis			Diabetes		
Emphysema			Thyroid		
Asthma			Genitourinary:		
Cardiovascular:			Kidney		
High Blood Pressure			Dialysis		
Chest Pain			Bladder		
Heart Attack			Yeast infections from antibiotics		
Heart Murmur			Gastrointestinal:		
Irregular Heartbeat			Crohns Disease		
Blood Clots			Ulcerative Colitis		
Pacemaker			GI upset from antibiotics		
Fainting			Musculoskeletal:		
Neurologic:			Osteoarthritis		
Seizures			Rheumatoid Arthritis		
Multiple Sclerosis			Artificial Joint		

If yes, please explain: _____

List any other diseases or conditions: _____

List surgical procedures you have had in the past: _____

Skin: Have you ever had skin cancer? YES NO

Has anyone in your family had skin cancer? YES NO Who? _____

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

Do you have problems with healing? YES NO

Do you develop keloids (scars) after surgery? YES NO

Do you bleed easily? YES NO

Do you develop skin rashes in reaction to: Medications Food Environment

Bandages Neosporin Other

Social History:

Do you drink alcohol? YES NO If YES _____ drinks per day

Do you use recreational drugs? YES NO If YES, what? _____ How often? _____

Do you smoke? YES NO If YES, how much: _____

Have you ever been exposed to HIV(AIDS)? YES NO

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

What is your occupation? _____ Hobbies? _____

Signature _____ Date ____/____/_____