DERMATOLOGY MEDICAL HISTORY

Patient:	Date of Birth:

Reason for Visit:

Are you allergic to any medications? ☐ Yes ☐ No If yes, list below:

List all Medications you are currently taking (including prescriptions, over-the-counter meds, vitamins and herbal

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	**YES**	**NO**
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Inflammation of Vein	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐

OTHER SYSTEMIC:	**YES**	**NO**
Diabetes	☐	☐
Excessive Thirst / Hunger	☐	☐
Amputation	☐	☐
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 Seizures	☐	☐
Fainting	☐	☐

Other Diseases / Conditions:

List any surgical procedures you have had in the past six months:

Skin:
- ☐ Have you ever had skin cancer? ☐ Yes ☐ No
- ☐ Has anyone in your family had skin cancer? ☐ Yes ☐ No
- ☐ Do you have a history of any specific skin diseases? ☐ Yes ☐ No
  If yes, which?
- ☐ Any family history of skin disease? If so, which:
- ☐ 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: ☐ Medication ☐ Food ☐ Environment ☐ Bandages ☐ Topical Neosporin ☐ Other

Social History

Do you drink alcohol? ☐ YES ☐ NO If YES, how many drinks per day?

Do you use IV drugs? ☐ YES ☐ NO If YES, what?

Do you smoke? ☐ YES ☐ NO if YES, how much?

Do you have or have you had any sexually transmitted diseases (STD's): ☐ YES ☐ NO

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

Women: Are you pregnant? ☐ YES ☐ NO Due Date: _____ Breastfeeding: ☐ YES ☐ NO

What is your occupation? Hobbies?

Patient Signature: _____ Date: _____

Completed by: ☐ Patient ☐ Medical Staff _____