

DERMATOLOGY MEDICAL HISTORY

Patient:	Date of Birth:		
Reason for Visit:			
Are you allergic to any medications? <input type="checkbox"/> Yes <input type="checkbox"/> 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	OTHER SYSTEMIC:	YES NO
Bronchitis	<input type="checkbox"/> <input type="checkbox"/>	Diabetes	<input type="checkbox"/> <input type="checkbox"/>
Emphysema	<input type="checkbox"/> <input type="checkbox"/>	Excessive Thirst / Hunger	<input type="checkbox"/> <input type="checkbox"/>
Asthma	<input type="checkbox"/> <input type="checkbox"/>	Amputation	<input type="checkbox"/> <input type="checkbox"/>
Chronic Cough	<input type="checkbox"/> <input type="checkbox"/>	Thyroid	<input type="checkbox"/> <input type="checkbox"/>
Morning Cough	<input type="checkbox"/> <input type="checkbox"/>	Kidney	<input type="checkbox"/> <input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/> <input type="checkbox"/>	Dialysis	<input type="checkbox"/> <input type="checkbox"/>
Wheezing	<input type="checkbox"/> <input type="checkbox"/>	Bladder	<input type="checkbox"/> <input type="checkbox"/>
CARDIOVASCULAR	YES NO	Frequency / burning	<input type="checkbox"/> <input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/> <input type="checkbox"/>
Chest Pain	<input type="checkbox"/> <input type="checkbox"/>	Stomach absorptive disorder	<input type="checkbox"/> <input type="checkbox"/>
Heart Attack	<input type="checkbox"/> <input type="checkbox"/>	Nausea, vomiting, diarrhea when taking antibiotics	<input type="checkbox"/> <input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/> <input type="checkbox"/>	Yeast infection when taking antibiotics	<input type="checkbox"/> <input type="checkbox"/>
Phlebitis	<input type="checkbox"/> <input type="checkbox"/>	Arthritis / Joint Deformity	<input type="checkbox"/> <input type="checkbox"/>
Inflammation of Vein	<input type="checkbox"/> <input type="checkbox"/>	Arthralgia	<input type="checkbox"/> <input type="checkbox"/>
Blood clots	<input type="checkbox"/> <input type="checkbox"/>	Limited Motion	<input type="checkbox"/> <input type="checkbox"/>
Pacemaker	<input type="checkbox"/> <input type="checkbox"/>	Artificial Joint	<input type="checkbox"/> <input type="checkbox"/>
Other Diseases / Conditions:		Convulsions, Epilepsy or Seizures	<input type="checkbox"/> <input type="checkbox"/>
		Fainting	<input type="checkbox"/> <input type="checkbox"/>
List any surgical procedures you have had in the past six months:			
Skin:			
<input type="checkbox"/> Have you ever had skin cancer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Has anyone in your family had skin cancer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Do you have a history of any specific skin diseases? If yes, which?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Any family history of skin disease? If so, which:			
<input type="checkbox"/> Do you have problems with healing?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Do you develop keloids (scars) after surgery?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Do you bleed easily?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Do you develop skin rashes in reaction to:		<input type="checkbox"/> Medication <input type="checkbox"/> Food <input type="checkbox"/> Environment <input type="checkbox"/> Bandages <input type="checkbox"/> Topical Neosporin <input type="checkbox"/> Other	
Social History			
Do you drink alcohol?		<input type="checkbox"/> YES <input type="checkbox"/> NO If YES, how many drinks per day?	
Do you use IV drugs?		<input type="checkbox"/> YES <input type="checkbox"/> NO If YES, what?	
Do you smoke?		<input type="checkbox"/> YES <input type="checkbox"/> NO if YES, how much?	
Do you have or have you had any sexually transmitted diseases (STD's):		<input type="checkbox"/> YES <input type="checkbox"/> NO	
Have you had or have you been exposed to HIV (AIDS)?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
Women: Are you pregnant?		<input type="checkbox"/> YES <input type="checkbox"/> NO Due Date: _____ Breastfeeding: <input type="checkbox"/> YES <input type="checkbox"/> NO	
What is your occupation?		Hobbies?	

Patient Signature: _____

Date: _____

Completed by: Patient Medical Staff _____