

Dermatology Medical History

Patient: _____

Date: _____

Reason for today's visit: _____

Are you allergic to any medications? YES NO If yes, list:
 1. _____ 2. _____

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

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):
 1. _____ 3. _____
 2. _____ 4. _____

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"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal		
			Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
			Nausea, vomiting, diarrhea when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
			Yeast infection when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
			Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
			Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
			Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
			Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
			Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>

Skin:

When you are exposed to sun do you: Tan only Tan and burn Burn
 Have you ever had skin cancer? YES NO
 Has anyone in your family had skin cancer? YES NO If YES, Who? _____
 Do you have a history of any specific skin diseases? YES NO
 If yes, please list: _____

Do you develop skin rashes in reaction to Medications Food Environment? _____

List any other diseases or conditions: _____

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

Social History:

Do you drink alcohol? YES NO If YES _____ drinks per day
 Do you use IV drugs? YES NO If YES, what? _____ How much? _____
 Do you smoke? YES NO If YES, how much: _____
 Have you had or have you been exposed to HIV (AIDS) ? YES NO

Please answer the following questions:

- A. Do you bleed easily? YES NO
- B. **(Women) Are you pregnant?** YES NO Due Date: _____
- C. What is your occupation ? _____
- D. What are your hobbies? _____

Completed by: Patient
 Medical Assistant _____
Initials

 Signed by Patient Date

 Reviewed by Date