

Dermatology Medical History

Name _____ Date _____

Reason for today's visit: _____

Do you have any specific skin diseases? _____

Please list all medications (including over-the-counter & herbals): _____

Are you allergic to any medications? Yes No Please list _____

What is your occupation? _____ Hobbies? _____

Do you have now, or have you ever had any of the following diseases or conditions?

	Yes	No		Yes	No
History of Cancer (other than skin)	<input type="checkbox"/>	<input type="checkbox"/>	Other Systemic		
Location _____			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Lungs			Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Frequent bladder infections	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infections on antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular			Fainting	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions or seizures	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/joint deformity	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack / heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Depression or anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal		
Inflammation of veins	<input type="checkbox"/>	<input type="checkbox"/>	Gastric bypass, sleeve, or lap band	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, vomiting, diarrhea		
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
			Celiac disease, Crohn's disease or	<input type="checkbox"/>	<input type="checkbox"/>
			ulcerative colitis		

List any other diseases or conditions: _____

List surgical procedures you have had in the last year: _____

Skin:

	Yes	No	
Have you ever had skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Body area & date of cancer _____
Has anyone in your family had melanoma?	<input type="checkbox"/>	<input type="checkbox"/>	Which family member? _____
Do you have problems with healing?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you develop keloids (bad scars) after surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you develop skin rashes in reaction to:	<input type="checkbox"/> Medications <input type="checkbox"/> Food <input type="checkbox"/> Environment? _____		

Social History:

	Yes	No	
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, _____ drinks per week; or, _____ drinks per month
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how many packs per day : _____
Does anyone around you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you wear sunscreen regularly?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have or have you been exposed to HIV (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>	

Women:

Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Due Date _____
Are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	
Are menstrual cycles regular?	<input type="checkbox"/>	<input type="checkbox"/>	Date of last cycle _____ <input type="checkbox"/> Menopause <input type="checkbox"/> Other _____

Signature _____