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
History of Cancer (other than skin)	☐	☐
Location______________		
Lungs		
Asthma	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐
Cardiovascular		
High blood pressure	☐	☐
Chest pain	☐	☐
Heart attack / heart disease	☐	☐
Heart murmur	☐	☐
Irregular heartbeat	☐	☐
Inflammation of veins	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐

Other Systemic	Yes	No
Diabetes	☐	☐
Thyroid problems	☐	☐
Kidney problems	☐	☐
Frequent bladder infections	☐	☐
Yeast infections on antibiotics	☐	☐
Fainting	☐	☐
Convulsions or seizures	☐	☐
Arthritis/joint deformity	☐	☐
Artificial joint	☐	☐
Depression or anxiety	☐	☐
Gastrointestinal		
Gastric bypass, sleeve, or lap band	☐	☐
Nausea, vomiting, diarrhea when taking antibiotics	☐	☐
Celiac disease, Crohn's disease or 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?	☐	☐	Body area & date of cancer__________________
Has anyone in your family had melanoma?	☐	☐	Which family member? __________________
Do you have problems with healing?	☐	☐	
Do you develop keloids (bad scars) after surgery?	☐	☐	
Do you bleed easily?	☐	☐	

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

Social History:	**Yes**	**No**	
Do you drink alcohol?	☐	☐	If yes, _____ drinks per week; or, _____ drinks per month
Do you smoke?	☐	☐	If yes, how many packs per day :____________
Does anyone around you smoke?	☐	☐	
Do you wear sunscreen regularly?	☐	☐	
Do you have or have you been exposed to HIV (AIDS)?	☐	☐	
Women:			
Are you pregnant?	☐	☐	Due Date__________
Are you breastfeeding?	☐	☐	
Are menstrual cycles regular?	☐	☐	Date of last cycle________ ☐ Menopause ☐ Other ______________

Signature______________________________