

# Dermatology Medical History

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Referring Physician Phone #: \_\_\_\_\_

Duration of problem: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

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

\_\_\_\_\_

Are you latex allergic?  Yes  No

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

\_\_\_\_\_  
\_\_\_\_\_

Do you have a personal history of any of the following: (Circle yes or no)

Diabetes_____	Yes	No	Thyroid disease_____	Yes	No
High blood pressure_____	Yes	No	Radiation therapy_____	Yes	No
Heart disease_____	Yes	No	HIV Infection_____	Yes	No
Lung disease_____	Yes	No	Kidney disease_____	Yes	No
Asthma/Allergies _____	Yes	No	Pacemaker_____	Yes	No
Arthritis_____	Yes	No	Implant defibrillator_____	Yes	No
Hepatitis_____	Yes	No	Artificial heart valve_____	Yes	No
Cancer (other than skin)_____	Yes	No	Joint replacement_____	Yes	No
Type_____			Bleeding disorder_____	Yes	No
Liver disease_____	Yes	No	Neurologic disease_____	Yes	No
Organ transplant _____	Yes	No	Seizures_____	Yes	No

List any other diseases or conditions: \_\_\_\_\_

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

**SKIN:** Have you ever had skin cancer?  YES  NO Type \_\_\_\_\_  
Has anyone in your family had skin cancer?  YES  NO  
Type Melanoma\_\_\_\_ Non-Melanoma\_\_\_\_  
Do you have any changing moles?  YES  NO  
Do you have a history of any specific skin disease?  YES  NO If yes, \_\_\_\_\_  
Do you have problems with healing?  YES  NO  
Do you develop abnormal scars after surgery? (keloids)  YES  NO  
Do you bleed easily?  YES  NO  
Do you develop skin rashes in reaction to:  Medications  Food  Environment  Bandages  Topical  Neosporin  
 Other \_\_\_\_\_

## SOCIAL HISTORY:

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

**(Women) Are you pregnant?**  YES  NO Due Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Are you breast feeding?  YES  NO

What is your occupation? \_\_\_\_\_