



DERMATOLOGY MEDICAL HISTORY

Patient _____ Date of Birth _____ Today's Date _____

Reason for today's visit _____

Do you have or have you had any of the conditions and/or diseases listed (please check Yes/No)

Lungs:	Yes	No		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"/>
			Frequency/Burning	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Absorptive Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, Vomiting, Diarrhea when	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	taking Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Yeast Infection when taking Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of Vein	<input type="checkbox"/>	<input type="checkbox"/>	Limited Motion	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Cancer:	<input type="checkbox"/>	<input type="checkbox"/>			

Type: _____

List any other conditions and/or diseases _____

List any surgical procedures you have had in the last 10 years _____

Skin: Have you ever had skin cancer?

Do you have problems withz healing?

Do you develop keloids (scars) after surgery?

Do you bleed easily?

Do you develop skin rashes in reaction to: Medication Food Environment Bandages

Topical Neosporin Other _____



Social History:

Do you drink alcohol? Yes No If YES _____ drinks per day

Do you use Recreational Drugs? Yes No If YES, What _____ How often? _____

Have you ever smoked? Yes No If YES, How often? _____

Have you had or have you been exposed to HIV (AIDS)? Yes No

Please answer the following questions:

(Women) Are you pregnant? Yes No Due Date _____

What is your occupation? _____ Hobbies? _____

Family History: Hypertension Cancer Diabetes Heart Disease Skin Disease

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

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

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

1. _____
2. _____

Have you ever had dental anesthesia (Novocaine)? Yes No Any bad reactions? Yes No

Completed by: Patient _____
 Signature by Patient _____ Date _____

Medical Assistant _____
 Initials _____

Reviewed by _____ Date _____