WASHINGTON DC DERMATOLOGY

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1140 Connecticut Ave. NW, Suite 675, Washington DC 20036
(One block from Farragut North, Two blocks from Farragut West Metro)

Dermatology Medical History

Patient _____ Date of Birth _____ Today's Date _____

Reason for todays visit _____

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

Lungs:	Yes	No
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐
Cardiovascular:	☐	☐
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heart Beat	☐	☐
Phlebitis	☐	☐
Inflammation of Vein	☐	☐
Blood Clots	☐	☐
Pacemaker	☐	☐
Cancer:	☐	☐
Type: _____		

	Yes	No
Diabetes	☐	☐
Excessive Thirst/Hunger	☐	☐
Amputation	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Dialysis	☐	☐
Bladder	☐	☐
Frequency/Burning	☐	☐
Gastrointestinal	☐	☐
Stomach Absorptive Disorder	☐	☐
Nausea, Vomiting, Diarrhea when taking Antibiotics	☐	☐
Yeast Infection when taking Antibiotics	☐	☐
Arthritis/Joint Deformity	☐	☐
Arthralgia	☐	☐
Limited Motion	☐	☐
Artificial Joint	☐	☐
Convulsions, Epilepsy or Seizures	☐	☐
Fainting	☐	☐

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 with 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 _____

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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 of Patient Date

☐ Medical Staff _____

_____ _____
Signature of Staff Date