Dermatology Medical History

Patient Name: ____ Date: _____/_____/_____

Reason for Today's Visit: ____

Allergies: Are you allergic to any medications, anesthesia, or latex? ❑ Yes ❑ No If yes, please list below:

Medications: List all medications you are currently taking (prescriptions, over-the-counter, vitamins & herbals): ❑ None

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Do you take any blood thinners (aspirin, Plavix, Coumadin, warfarin, Aggrenox, etc.)? ❑ Yes ❑ No

Medical History: Have you had or currently have diseases in the following organs (if yes, please list):

Asthma	❑ Yes	❑ No	________________	Infections	❑ Yes	❑ No	__________________
Arthritis	❑ Yes	❑ No	________________	Immunosuppression	❑ Yes	❑ No	__________________
Artificial joint	❑ Yes	❑ No	________________	Kidney	❑ Yes	❑ No	__________________
Artificial heart valve	❑ Yes	❑ No	________________	Liver (cirrhosis)	❑ Yes	❑ No	__________________
Blood Pressure	❑ Yes	❑ No	________________	Lungs	❑ Yes	❑ No	__________________
Cancer	❑ Yes	❑ No	________________	Lupus	❑ Yes	❑ No	__________________
Congenital Defect	❑ Yes	❑ No	________________	Neurologic	❑ Yes	❑ No	__________________
Diabetes	❑ Yes	❑ No	________________	Organ Transplant	❑ Yes	❑ No	__________________
Fainting Easily	❑ Yes	❑ No	________________	Pacemaker	❑ Yes	❑ No	__________________
Gastrointestinal	❑ Yes	❑ No	________________	Platelet Disorder	❑ Yes	❑ No	__________________
Heart Attack	❑ Yes	❑ No	________________	Sarcoid	❑ Yes	❑ No	__________________
Heart (other)	❑ Yes	❑ No	________________	Seizures	❑ Yes	❑ No	__________________
Hepatitis B or C	❑ Yes	❑ No	________________	Stroke	❑ Yes	❑ No	__________________
HIV (AIDS)	❑ Yes	❑ No	________________	Thyroid	❑ Yes	❑ No	__________________

Surgical History: Please list all surgeries that you have had:

Skin History:

Have you ever had skin cancer?	❑ Yes	❑ No	Types: ______________________________________
Has anyone in your family had skin cancer?	❑ Yes	❑ No	Types: ______________________________________
Do you have a history of specific skin disease?	❑ Yes	❑ No	Types: ______________________________________
Do you have a family history of skin disease?	❑ Yes	❑ No	Types: ______________________________________
Do you develop keloids after surgery?	❑ Yes	❑ No	
Do you bleed easily?	❑ Yes	❑ No	

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

Social History:

Do you drink alcohol?	❑ Yes	❑ No	If yes, ____________ drinks per day
Do you smoke?	❑ Yes	❑ No	If yes, ____________ packs per day
Do you use illicit drugs?	❑ Yes	❑ No	If yes, what: ___________________
Do you have or have you been exposed to:	❑ HIV (AIDS)		❑ Hepatitis C
(Women only) Are you pregnant?	❑ Yes	❑ No	Due date: _____/_____/_____
(Women only) Are you breastfeeding?	❑ Yes	❑ No	

What is your occupation? ___________________________________Hobbies?___________________________________

____ _____/_____/_____
Patient Signature Date

____ _____/_____/_____
Reviewed By Date

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