Dermatology Medical History

Name: ____ Date of Birth:___/___/____ Date:__/___/____
E-mail address:____________________________________
Primary Care Doctor: ______________________________________

MEDICINES you are taking (prescription, over-the-counter, supplements, vitamins, etc.) and condition(s) for which they are being taken, if applicable:

1) ____ 2) ____
3) ____ 4) ____
5) ____ 6) ____
7) ____ 8)____
9)____ for additional, please check here ☐ & continue on back

MEDICATION ALLERGIES (please list & describe reaction, if any, or check ☐ None): _________________

____

Have you ever had a reaction to local anesthesia (like dental anesthesia, novocaine, etc.)? ☐ Yes ☐ No
If yes, please describe the reaction:____

MEDICAL CONDITIONS: Do you have diseases or conditions of any of the below? (Please check YES or NO)

Lungs:	Yes	No	Other systemic conditions:	Yes	No
Bronchitis	☐	☐	Diabetes	☐	☐
Emphysema	☐	☐	Thyroid	☐	☐
Asthma	☐	☐	Kidney	☐	☐
Chronic cough	☐	☐	Dialysis	☐	☐
Shortness of breath	☐	☐	Liver:		
Wheezing	☐	☐	hepatitis	☐	☐
Cardiovascular:			cirrhosis	☐	☐
High blood pressure	☐	☐	Arthritis/Joint pain	☐	☐
Chest pain	☐	☐	Artificial joint	☐	☐ (If yes, please specify
Stroke	☐	☐	which is/are affected) ___________________________		
History of heart attack	☐	☐	Gastrointestinal (e.g. Crohn's, irritable bowel,		
Irregular heartbeat	☐	☐	ulcerative colitis, celiac)	☐	☐
Blood clot	☐	☐	Convulsions, epilepsy, seizures	☐	☐
Pacemaker/defibrillator	☐	☐	Fainting	☐	☐
Easy bruising	☐	☐	Other:_____________________________________		

Skin:

Have you ever had skin cancer? ☐ Yes ☐ No If yes, what type(s)? ☐ melanoma ☐ squamous cell ☐ basal cell ☐ unsure ☐ other: _______________

If yes, indicate type, location & method of treatment of most recent skin cancer: ____

Year of treatment _________

Has any of your family had skin cancer? ☐ Yes ☐ No If yes, who and what kind?__________________________

Have you been diagnosed with a skin disease? ☐ Yes ☐ No If yes, what kind?___________________________

Does your skin heal with thick, raised scars (keloids) after injuries or surgeries? ☐ Yes ☐ No

Have you had any surgeries? ☐ Yes ☐ No If yes, please specify: ___________________________________

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____________

How much do you smoke? ___________________________________ ☐ I don’t smoke

(For females)Are you: pregnant? ☐ Yes ☐ No If yes, when is your due date? ____/_____/_______

or breastfeeding? ☐ Yes ☐ No

What is your occupation?_________________________ Hobbies: _____________________________________

Reason for today’s visit:____

Additional comments, including additional medical history or medications:

Patient signature __________________________________ Date signed: ___/____/_____

Reviewed by ____________________________________ Date: ___/____/_____

Skin Health Dermatology, PLLC

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