

Dermatology Medical History

Patient: _____ Date of Birth: ____/____/____ Today's Date: ____/____/____

Reason for today's visit: _____

List of Current Medications		List any Drug Allergies
1	6	1
2	7	2
3	8	3
4	9	4
5	10	5

Do you have now, or have you ever had diseases or conditions of: (please check Yes or No)

Lungs:	Yes	No	Other Systemic	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:	Yes	No	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		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection when		
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clot	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
			Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>

Skin:

Have you ever had skin cancer? Yes No

Has anyone in your family has skin cancer? Yes No

Do you have a history of any specific skin diseases? Yes No If yes _____

Do you have problems healing? Yes No

Do you develop hypertrophic scars after surgery? Yes No

Do you bleed easily? Yes No

Do you develop skin rashes in reaction to Medications Food Environment Bandages Topical Neosporin

Other _____

List any other diseases or conditions: _____

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

Social History:

Do you drink alcohol? YES NO If yes _____ per day

Do you smoke? YES NO If yes how much _____

Do you use IV drugs? YES NO If yes, what? _____ How often? _____

Have you had or have you been exposed to HIV (AIDS)? YES NO

Women only: Are you pregnant? YES NO Due Date: ____/____/____

Date of Last Menstrual period: ____/____/____