

Sex: Female \_\_\_ Male \_\_\_

Ethnicity/Race: \_\_\_\_\_

# Dermatology Medical History

Patient Name: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

Reason for today's visit: \_\_\_\_\_

Does anyone in your family have this problem?  Yes  No If yes who: \_\_\_\_\_

The following information is very important to your health. Please take time to **fully and completely fill out** this important information.

Any Medication **Allergies?**  Yes  No if yes **what:** \_\_\_\_\_

**\*\*Please list Reaction/ When (ie:rash/2001):** \_\_\_\_\_

List all medications you are currently taking including strength (ie: Lipitor 10 mg) **or Can Provide a List**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_

Do you have now or have you ever had any of the problems below? Please check Yes or No

	Yes	No		Yes	No	Elaborate
<b>Lungs:</b>			<b>Other Systemic:</b>			
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hyper or Hypo
COPD	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Cardiovascular:</b>	<b>Yes</b>	<b>No</b>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	GERD	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy, Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Stent	<input type="checkbox"/>	<input type="checkbox"/>	<b>History of Skin Cancer</b>	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	<b>Artificial Joint</b>	<input type="checkbox"/>	<input type="checkbox"/>	Where: _____
<b>Pacemaker</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Amputation</b>	<input type="checkbox"/>	<input type="checkbox"/>	Where: _____

List any other diseases or conditions (or surgeries in the last 6 mo): \_\_\_\_\_

**Skin:** Has anyone in your family had skin cancer?  Yes  No Who: \_\_\_\_\_ Type: \_\_\_\_\_  
 Do you have a history of any specific skin disease?  Yes  No What: \_\_\_\_\_  
 Do you have any sensitivity to antibiotics?  Yes  No What: yeast infections/upset stomach \_\_\_\_\_  
 Do you develop keloids(raised scars) after surgery?  Yes  No  
 Do you develop skin rashes from:  Bandages  Neosporin  Other \_\_\_\_\_

**Social History:**  
 Do you drink alcohol?  Yes  No if yes, (how many) \_\_\_\_\_ beer/ wine/ liquor per Day /Week /Month /Occasional  
 Do you use tobacco/smoke?  Yes  No **or** Have you ever?  Yes  No if yes, What? \_\_\_\_\_  
 Currently how much: \_\_\_\_\_ **or** When did you quit? \_\_\_\_\_  
 History of Substance use or IV drugs?  Yes  No if yes, What? \_\_\_\_\_ How often: \_\_\_\_\_  
 Do you have Hep, HIV (AIDS)?  Yes  No or have you ever been exposed?  Yes  No  
**Women:** Are you Pregnant?  Yes  No Due date: \_\_\_/\_\_\_/\_\_\_

What is your occupation? \_\_\_\_\_  retired  student Hobbies? \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Cross Streets (or address if know it): \_\_\_\_\_

The above is true and correct to the best of my belief.

**\*\*Patient Signature:** \_\_\_\_\_

Form Completed by:  Patient  
 \_\_\_\_\_

Reviewed with patient by: \_\_\_\_\_, MA (Entered in EMR: )

MA Notes: \_\_\_\_\_