



DERMATOLOGY MEDICAL HISTORY FORM

Name (Printed): _____ DOB: _____ Height: _____ Weight: _____

General Medical History: Do you have or have you ever had any of the following?

<p>Y N Pacemaker or Defibrillator Y N Asthma Y N Hay fever, seasonal allergies Y N Bronchitis Y N Eczema Y N Psoriasis Y N Diabetes, controlled with (Circle) diet, medication, insulin Y N High Cholesterol Y N High Blood Pressure Y N Angina/Coronary Artery disease Y N Congestive Heart Failure Y N Heart murmur or heart valve problem Y N Have you been told to take antibiotics before a dental procedure due to a heart murmur, heart valve, or artificial joint?</p> <p>Surgeries:</p> <p>Y N Abnormal moles proven on biopsy Y N Heart valve replacement</p>	<p>Y N Acne & or Rosacea Y N Scleroderma Y N Overgrown scars or keloids Y N Kidney problems (what type?) _____ Y N Epilepsy or seizures Y N Crohn's disease or ulcerative colitis Y N Arthritis (if yes, osteoarthritis, rheumatoid or psoriatic?) Y N Thyroid problems (what type?) _____ Y N Osteoporosis Y N Organ transplant (what type?) _____ Y N Fibromyalgia Y N Reflux/GERD/Heartburn or peptic ulcers Y N Emphysema or COPD Y N Melanoma (if yes, year _____ location _____) Y N Basal cell or Squamous cell skin cancer (if yes, year _____ location _____) Y N Artificial joint (if so, where _____/when _____)</p>	<p>Y N Sarcoid Y N HIV or AIDS Y N Hepatitis (what type?) _____ Y N Multiple sclerosis Y N Lupus (circle) Systemic/Discoid Y N Liver cirrhosis or other liver problems Y N Herpes (circle) genital/mouth/shingles Y N Genital warts Y N Blistering sunburns Y N Tuberculosis Y N Blood clots in legs (DVT) Y N Anemia (circle) Iron or Folate Y N Blood transfusion (when _____) Y N Bleeding disorder, type _____ Y N Anxiety Y N Depression or other psychological condition, type _____ Y N Cancer (type _____ when _____ how treated?) _____ Y N Gallbladder removed Y N Heart bypass surgery</p>
<p>Female Patients:</p> <p>Y N Are you pregnant or breastfeeding, if not, method of birth control _____</p>	<p>Y N Are you planning to get pregnant If so, when _____</p> <p>Y N Hysterectomy (if yes, uterus only or uterus and ovaries- circle one)</p>	<p>Y N Prone to yeast infections with antibiotics Y N Tubal ligation (tubes tied)</p>



DERMATOLOGY MEDICAL HISTORY FORM

Any prior dermatology history?

Other medical problems or surgeries?

Current medications being taken (include prescription and non-prescription and herbal)? Include strength and dosage amounts

Allergies to any medications or latex?

Have you had your flu shot? (Circle one) YES NO Pneumonia vaccine? (Circle one) YES NO

Do you have a living will? (Circle one) YES NO

Social History: Do you smoke or use tobacco? Y N Do you drink alcohol? Y N Number per day _____ week _____ year _____

Marital status _____ # of children _____ Hobbies _____ Student? _____

Occupation _____

Family History: Circle any conditions affecting a *blood relative*. Specify who is affected below the circled answer.

Melanoma Basal cell or squamous cell skin cancer Breast cancer Psoriasis Eczema Acne

Lupus Sarcoid/Keloids Asthma Hay fever/allergies Rosacea

Signature of patient or parent/guardian of patient: _____

Printed Name: _____ **Date:** _____