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Dermatology Medical History

Patient's Name: ________________________________ DOB: _________ Today's Date: _____________

Primary Care Physician:________________________ Date of Last Visit w/ Primary Care Physician: __________

Reason for Today's Visit: ____

Visit Type (circle one): MEDICAL COSMETIC

Past Medical History (circle those which apply):

ASTHMA	HEART MURMUR	BLADDER	NO PAST MEDICAL HISTORY
BRONCHITIS	BLOOD CLOTS	-- FREQUENCY/BURNING	
EMPHYSEMA	PHLEBITIS	GASTROINTESTINAL	
SHORTNESS OF BREATH	HEPATITIS	-- DIARRHEA/CONSTIPATION	
HIGH BLOOD PRESSURE	FAINTING	YEAST INFECTION WITH ANTIBIOTICS	
CHEST PAIN/TIGHTNESS	DIABETES	ARTHRITIS/JOINT DEFORMITY	
HEART DISEASE	--EXCESSIVE THIRST/HUNGER	TUBERCULOSIS	
HEART ATTACK	KIDNEY	SEIZURES	
CANCER	THYROID	ULCERS	

Past Surgical History:

	SURGERY/HOSPITALIZATION	DATE	ANESTHESIA COMPLICATIONS
1.	____________________________	____________	YES/NO
2.	____________________________	____________	YES/NO
3.	____________________________	____________	YES/NO

Past Skin History (circle those which apply):

NO SIGNIFICANT SKIN HISTORY

ECZEMA	BASAL CELL CARCINOMA	KELOIDS
ROSACEA	MALIGNANT MELANOMA	OTHER SUSPICIOUS LESION
PSORIASIS	SQUAMOUS CELL CARCINOMA	

Female Questions:

PREGNANT	YES/NO
BREAST FEEDING	YES/NO

Patient Family History (circle those which apply AND list which family member affected):

ADOPTED	HEART DISEASE	LUNG CANCER	NO FAMILY MEDICAL HISTORY
ABNORMAL BLEEDING	HIGH BLOOD PRESSURE	SKIN CANCER	
ABNORMAL CLOTTING	HEMOPHILIA	BREAST CANCER	
AUTOIMMUNE DISORDERS	KIDNEY DISEASE	OVARIAN CANCER	
BRAIN TUMOR	LIVER DISEASE	PROSTATE CANCER	
DIABETES	SKIN DISEASE	COLON CANCER	
ENDOCRINE DISEASE	MALIGNANT MELANOMA	OTHER CANCER	

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Patient's Height: ________________ **Patient's Weight: ________________**

Social History (circle the answer which applies):

ALCOHOL

I DO NOT DRINK ALCOHOL

I DRINK ALCOHOL SOCIALLY

I DRINK ALCOHOL DAILY

-IF YOU CONSUME ALCOHOL DAILY, PLEASE CIRCLE ONE OF THE CHOICES BELOW:

-I CONSUME **MORE THAN 3** ALCOHOLIC DRINKS DAILY

-I CONSUME **LESS THAN 3** ALCOHOLIC DRINKS DAILY

ILLEGAL DRUGS	**HIGH RISK FACTORS**	**STD**
I DENY USING ILLEGAL DRUGS	I DENY HIGH RISK FACTORS	I DENY HAVING AN STD HISTORY
I ADMIT TO USING ILLEGAL DRUGS	I ADMIT TO HIGH RISK FACTORS	I ADMIT TO HAVING AN STD HISTORY

SMOKING STATUS

CURRENT EVERYDAY SMOKER FORMER SMOKER

CURRENT SOME DAY SMOKER NEVER SMOKER

Have you received a FLU vaccination this season? (please circle one): YES/NO

- If YES, what month did you receive the FLU vaccination: ________________________

***If you are 65 OR ABOVE, do you currently have Advanced Care Planning (i.e. a Living Will)? (please circle one):** YES/NO

- If YES, what year was your Advance Care Planning created: _____________________

***If you are 65 OR ABOVE, have you received the Pneumonia vaccination? (please circle one):** YES/NO

- If YES, what year did you receive the Pneumonia vaccination: ____________________

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Dermatology Medical History

Patient's Name: _________________________________ DOB: __________ Today's Date: __________

Are you allergic to any medications? (please circle one): YES/NO

If YES, please list which medications you are allergic to below:

1.	____________________	**6.**	____________________
2.	____________________	**7.**	____________________
3.	____________________	**8.**	____________________
4.	____________________	**9.**	____________________
5.	____________________	**10.**	____________________

Are you currently taking any medications? (please circle one): YES/NO

If YES, please list which medications you are currently taking below:

1.	____________________	**6.**	____________________
2.	____________________	**7.**	____________________
3.	____________________	**8.**	____________________
4.	____________________	**9.**	____________________
5.	____________________	**10.**	____________________