Dermatology Medical History

Patient's Name: _____ DOB: _____ Today's Date: _____

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: _____

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. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

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

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

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____