

Dermatology Medical History

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

Reason for today's visit: _____

Are you allergic to any medications? YES NO If yes, please list _____

Have you ever had a bad reaction to dental or other anesthesia? YES NO Please explain _____

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals)

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

Are you currently taking any blood thinners? YES NO

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Skin

Chronic skin disease: YES NO

Skin cancer: YES NO If yes, date and what type of skin cancer: _____

Problems with healing or scarring: YES NO

Excessive bruising or bleeding: YES NO

Develop skin rashes to medications, bandages, topical antibiotics: YES NO

Sun sensitivity: YES NO

Heart

High Blood pressure: YES NO

Heart Attack: YES NO

Heart murmur or trouble with your heart valves: YES NO

Artificial heart valve: YES NO

Pacemaker or defibrillator: YES NO

Blood clots or inflammation of the veins: YES NO

Other systems

Frequent cold sores: YES NO

Eye discomfort: YES NO

Diabetes: YES NO

Thyroid abnormalities: YES NO

Kidney problems: YES NO If yes, are you being considered for dialysis? YES NO

Asthma: YES NO

Emphysema/bronchitis: YES NO

Chronic cough: YES NO

Nausea/vomiting/diarrhea when taking antibiotics: YES NO

Intolerance to bread products: YES NO

Yeast infections when taking antibiotics: YES NO

Artificial joint: YES NO

Arthritis: YES NO

Fainting after a procedure: YES NO

Seizures: YES NO

Are you feeling well today? YES NO If NO, please explain: _____

Women only:

Are you pregnant: YES NO Due date: _____

Are you breastfeeding? YES NO

Please list any other recent disease or surgical procedures: _____

Social History

Do you smoke: YES NO

Do you drink alcohol? YES NO If YES, _____ drinks per day

Family History – please list major diseases that run in your family (including skin cancer)

Completed by: patient _____

Signed by Patient/Guardian _____ / / _____
Date