DERMATOLOGY, P.C. MEDICAL HISTORY

Name _____ Date of Birth _____ Sex ___ F ___ M
Please Print - Last, First, Middle

DRUG ALLERGIES (state reaction)

☐ No Known Drug Allergies
☐ Local Anesthetics _____
☐ Other, Please list drug(s) and reaction _____
_____
☐ See attached list

ALLERGIES

☐ No Known Allergies

Do you develop skin rashes in reaction to:

☐ Medications ☐ Environment ☐ Latex
☐ Food ☐ Other _____

CURRENT MEDICATIONS

☐ None
Please list medication(s) _____
_____
☐ See attached list _____

CURRENT VITAMINS / SUPPLEMENTS

☐ None
Please list current _____
vitamins & supplements _____
☐ See attached list _____

GENERAL PERSONAL AND FAMILY HISTORY (check all that apply)

Disease	Self	Parent	Blood Relative
Arthritis	☐	☐	☐
Asthma	☐	☐	☐
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Heart Disease	☐	☐	☐
(Pacemaker)/Defibrillator	☐		
Phlebitis (blood clots)	☐	☐	☐

Disease	Self	Parent	Blood Relative
High Blood Pressure	☐	☐	☐
Kidney Disease	☐	☐	☐
Liver Disease	☐	☐	☐
Lung Disease	☐	☐	☐
Lupus	☐	☐	☐
Melanoma	☐	☐	☐
Neurological Problem	☐	☐	☐
Skin Cancer	☐	☐	☐

Influenza shot ☐ Yes ☐ No Last date _____
TB test ☐ Yes ☐ No Last date _____
Pneumovax Vac ☐ Yes ☐ No Last date _____
(Recommended for patients 65 years+)

Other _____
_____

Do you need to take antibiotics prior to surgery? ☐ No ☐ Yes

REVIEW OF SYSTEMS

Do you bruise or bleed easily? ☐ No ☐ Yes
Do you have poor circulation? ☐ No ☐ Yes
Do you develop yeast infection when taking antibiotics? ☐ No ☐ Yes
Do you develop GI problems when taking antibiotics? ☐ No ☐ Yes
Do you have blood borne infectious diseases? (i.e. HIV, HEP B or C) ☐ No ☐ Yes

DERMATOLOGICAL PERSONAL REVIEW (check all that apply)

Disorder	Active	History	Disorder	Active	History
Acne	☐	☐	Pigment changes	☐	☐
Bruise easily	☐	☐	Psoriasis	☐	☐
Eczema	☐	☐	Scarring/Keloids	☐	☐
Hair loss	☐	☐	STD/Venereal disease	☐	☐
Herpes simplex	☐	☐ (cold sores)	Varicose Veins	☐	☐
Herpes zoster	☐	☐ (shingles)	Vitiligo	☐	☐
Hives	☐	☐	Warts	☐	☐
			Wound healing problem	☐	☐

Other: _____

MAJOR SURGERIES/ILLNESSES

(list any procedures within the last 5 years)

☐ None
☐ Artificial Joint
☐ Heart Valve
☐ Other: _____
_____
_____

SKIN CARE

Do you regularly examine your skin for any changes? ☐ No ☐ Yes
Have you ever noticed a changing mole(s)? ☐ No ☐ Yes; Has a physician examined and treated the mole(s)? ☐ No ☐ Yes
When you are exposed to the sun, do you ☐ Tan ☐ Tan and Burn ☐ Burn ☐ Other _____
Do you regularly use sun screen when exposed to the sun? ☐ No ☐ Yes
Do you use tanning beds? ☐ No ☐ Yes; how often _____

SOCIAL HISTORY

Women: Are you pregnant? ☐ No ☐ Yes; Due Date: _____
Women: Are you actively nursing? ☐ No ☐ Yes
Do you use tobacco products? ☐ No ☐ Yes; how much? _____ per day
Do you drink alcohol? ☐ No ☐ Yes; how much? _____drinks per day

Clinical Office Review
Date/Initials

_____ _____ _____ _____
_____ _____ _____ _____

_____
Signature (Parent or Guardian, if a minor) Date