

Dermatology Medical History

Name _____ Date _____

Reason for today's visit: _____

Do you have any specific skin diseases? _____

Please list all medications (including over-the-counter & herbals): _____

Are you allergic to any medications? Yes No Please list _____

What is your occupation? _____ Hobbies? _____

Do you have now, or have you ever had diseases or conditions of:

	Yes	No		Yes	No
Lungs			Other Systemic		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Frequent bladder infections	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infections on antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular			Convulsions or seizures	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/joint deformity	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Limited joint motion	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal		
Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of veins	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, vomiting, diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>			

List any other diseases or conditions: _____

List surgical procedures you have had in the last year: _____

Skin:

	Yes	No	
Have you ever had skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Location & date _____
Has anyone in your family had melanoma?	<input type="checkbox"/>	<input type="checkbox"/>	Who? _____
Do you have problems with healing?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you develop keloids (bad scars) after surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you develop skin rashes in reaction to:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Medications <input type="checkbox"/> Food <input type="checkbox"/> Environment? _____

Social History:

	Yes	No	
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, _____ drinks per day
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much: _____
Do you wear sunscreen daily?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have or have you been exposed to HIV (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>	

Women:

Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Due Date _____
Are menstrual cycles regular?	<input type="checkbox"/>	<input type="checkbox"/>	Date of last cycle _____

Signature _____