

Tab:
Patient:
Physician:

File:
DOB:
DOS:

ID:

DERMATOLOGY MEDICAL HISTORY

Patient:	Date:
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Reason for today's visit:

Are you allergic to any medications: YES NO If yes, list below:

1. _____ 2. _____ 3. _____

Have you ever had dental anesthesia (Novocaine)? YES NO Any bad reaction: YES NO

List all medication you are currently taking (including prescriptions, over the counter meds, vitamins and herbals):

1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____

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

	YES	NO	OTHER SYSTEMIC:	YES	NO
Lungs:			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Amputation	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
			Gastrointestinal		
Cardiovascular:			Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, vomiting, diarrhea		
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection when taking		
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

SKIN:	Have you ever had skin cancer?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Has anyone in your family had skin cancer:	<input type="checkbox"/>	<input type="checkbox"/>	
	Do you have a history of any specific skin diseases?	<input type="checkbox"/>	<input type="checkbox"/>	If yes _____
	Do you have problems with healing?	<input type="checkbox"/>	<input type="checkbox"/>	
	Do you develop keloids (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 MedicationsFoodEnvironmentBandagesTopical Neosporin?

Social History:			
Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, _____ drinks per day		
Do you use IV drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what? _____	How often?	_____
Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much? _____		

Have you had or have you been exposed to HIV (AIDS)? Yes No

WOMEN: Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Due Date: ___/___/___
What is your occupation? _____	Hobbies? _____
Completed by: <input type="checkbox"/> Patient	Sign by Patient _____ Date: _____
<input type="checkbox"/> Medical Assistant Initials: _____	Reviewed by: _____ Date: _____