

Dermatology Center Medical History

Patient: _____ Date: ___/___/___

Who referred you? I have been a previous patient Family or Friend Phone Book Insurance Plan

Doctor _____ City _____

Reason for today's visit: _____

What treatment have you used for the problem? _____

Have you seen a doctor for this before? YES NO When? _____ Treatment _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO If yes, list below:

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

Do you have now, or have you ever had any of the following: (Please check YES or NO)

Respiratory:	YES	NO	Other Systemic:	YES	NO
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	HIV (AIDS)	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:			Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	List any other diseases or conditions		
Gastrointestinal:			_____		
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____		

List serious illness or surgical procedures you have had in the last 6 months:

Skin:

Have you ever had skin cancer? YES NO Type _____ When? _____

Has anyone in your family had melanoma skin cancer? YES NO Who? _____

Do you have a history of eczema (atopic dermatitis)? YES NO

Has anyone in your family had asthma hay fever eczema? Who? _____

Do you have a history of any other specific skin diseases? YES NO What? _____

Do you develop skin rashes in reaction to Bandages Topical Neosporin (antibiotic) Latex

Do you smoke? YES NO

Did you ever use a tanning parlor? YES NO When _____ How much _____

What is your Height _____ Weight _____ Occupation _____

FOR WOMEN ONLY: Are you pregnant or trying to get pregnant? YES NO Due Date: ___/___/___

I understand that if I am trying to get pregnant or I become pregnant I will stop all oral and topical medications you have prescribed and contact this office. Please initial here _____

Patient Signature _____ Date ___/___/___

Reviewed by Nurse/Med. Asst. _____ Doctor/P.A. _____