Date _____

MEDICAL HISTORY – DERMATOLOGY

Name_____ Date of Birth _____

List/Describe the reason(s) you have come to see the doctor:

1) _____
2) _____
3) _____

List any medication that you are allergic to and describe the reaction you had: _____

_____

_____

List any medication which you are currently taking. Include over the counter medications, multivitamins, birth control, blood thinners and any hormone therapy: _____

_____

_____

_____

Medical history. Circle any of the following conditions which you have:

Ht. _____ Wt. _____

Arthritis	Chest Pain	Kidney Disease
Artificial Joints	Diabetes	Pacemaker
Asthma	Hepatitis	Radiation Treatment
Blood Transfusions	HIV/AIDS	Seizures
Breathing Problems	Irregular or Fast Heart Beat	Valve Replacement

List any other heart problems:_____

List any other lung problems: _____

List any surgeries, hospitalizations, or other medical problems you have had: _____

_____

_____

Do you presently use sunscreen? NO YES If so, what SPF number_____

Circle any of the following that you have had:

Acne	Blistering Sunburn	Hayfever	Precancers	Skin Cancer
Allergies	Eczema	Melanoma	Psoriasis	Sun Sensitivity

Have you ever had difficulty stopping bleeding? NO YES

Do you require antibiotics prior to any surgical or dental procedure: NO YES

Are you pregnant or currently trying to get pregnant? NO YES

Family History. Circle any below that anyone in your family has had:

Acne	Asthma	Hayfever	Psoriasis	Sun Sensitivity
Allergies	Eczema	Melanoma	Skin Cancer	

Social history. Your occupation: _____

Have you had any occupational sun exposure or radiation exposure? NO YES

Have you had any occupational arsenic or petrol products exposure? NO YES

Name_____Date_____

Do you smoke? NO YES If yes, how much?_____

Do you drink beer, wine or liquor? NO YES If yes, how much?_____

Do you use any street drugs? NO YES If yes, please list:_____

Review of Systems. Circle any of the following as they apply to you now or in the past:

Asthma	Glaucoma	Prostate Problems
Bloody Stool	Hearing Loss	Shingles
Bloody Urine	High Cholesterol	Shortness of Breath
Bronchitis	High Triglyceride	Stroke
Chicken Pox	HIV/AIDS	Tuberculosis
Colitis	Hypertension	Ulcer
Difficulty Urinating	Loss of Strength	Urinary Infection
Emphysema	Paralysis	
Gallstones	Persistent Vomiting	

Reviewed by:_____
Physician