Dermatology Medical History

Patient: _____

DOB: _____Account #: _____ Date: ____/____/____

Are you allergic to any medications? YES NO If yes, list below:
1._____ 2. _____
3. _____ 4. _____

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

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):
1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

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

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

List any other diseases, conditions or allergies_____

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

Skin:

Have you ever had skin cancer?	YES	NO	If yes, when
Has anyone in your family had skin cancer?		YES	NO
Do you have a history of any specific skin diseases?		YES	NO If yes, _____
Do you have problems with healing	YES	NO	
Do you develop keloids (scars) after surgery		YES	NO
Do you bleed easily?		YES	NO

Do you develop skin rashes in reaction to: Medications Food Environment?
____

Have you had or have you been exposed to HIV (AIDS)? YES NO

(Women) Are you pregnant? YES NO Due Date: ___/___/___

How did you hear about our clinic? ____________________________

Patient Signature ____Date ___/___/___