DERMATOLOGY SOUTHWEST

Dermatology Medical History

Patient: _____ Date of Birth: ___/___/___ Today's Date: ___/___/___

Reason for today's visit: _____

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

1. _____ 2. _____

Have you ever had dental anesthesia (Novocain)? ☐ YES ☐ NO 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 disease of conditions of: (Please check YES or NO)

Lungs:	YES	NO
Bronchitis		
Emphysema		
Asthma		
Chronic Cough		
Morning Cough		
Shortness of Breath		
Wheezing		

Cardiovascular:		
High Blood Pressure		
Chest Pain		
Heart Attack		
Heart Murmur		
Irregular Heartbeat		
Phlebitis		
Inflammation of vein		
Blood clots		
Pacemaker		

Other Systemic	YES	NO
Diabetes		
Excessive thirst/hunger		
Amputation		
Thyroid		
Kidney		
Dialysis		
Bladder		
Frequency/burning		
Gastrointestinal stomach absorptive disorder		
Nausea, vomiting, diarrhea when taking antibiotics		
Yeast infection when taking antibiotics		
Arthritis/Joint Deformity		
Arthralgia		
Limited Motion		
Artificial Joint		
Convulsions, Epilepsy or Seizure, Fainting		

List any other diseases of conditions: _____

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

Skin:
- Have you ever had skin cancer? ☐ YES ☐ NO
- 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: ☐ Medication ☐ Food ☐ Environment ☐ Topical ☐ Neosporin ☐ Other: _____

Social History:

Do you drink alcohol? ☐ YES ☐ NO If YES _____ Drinks per day

Do you use IV drugs? ☐ YES ☐ NO If YES, what? _____ How often? _____

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

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

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

What is your occupation? _____ Hobbies? _____