

Dermatology Medical History

Name: _____ Date: ___ / ___ / ___

Reason for today's visit: _____ How Long: _____

Allergies to medications: _____ Reaction: _____

List all current medications you are currently taking (inc. prescriptions, over-the-counter meds, vitamins and herbs):

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

Do you have now or have a history of any skin disease/disorder? _____

Do you develop skin rashes/hives in reaction to food or environment? Please list _____

Do you drink alcohol? No Yes - socially, seldom, occasionally, often (daily)

Do you smoke? No Yes - how much _____

Do you bleed easily? No Yes - due to _____

Have you had local numbing (Xylocaine/Novicaine)? No Yes Bad reaction? No Yes

Do you develop keloids (raised scars) after surgery? No Yes

Are you pregnant (women)? No Yes - How many weeks/months? _____

Have you ever had skin cancer? No Yes - BCC (basal cell), SCC (squamous cell), or MM (melanoma)
Location: _____ Year: _____

Any family members have skin cancer? No Yes - who? mother, father, brother, sister, daughter, son
Type: BCC (basal cell), SCC (squamous cell), or MM (melanoma)

Have you ever had any moles removed? No Yes - How many _____ Was the pathology: normal / abnormal

Have you ever had precancers/AK's treated with liquid nitrogen? No Yes - Where? _____

Please CIRCLE the following diseases or conditions you have now or have had in the past 6 months:

Constitutional : weight loss, weight gain, appetite change, fatigue, dizziness

Neurological : headaches, convulsions, seizures, trauma to the head, numbness, paralysis, stroke

Eyes : irritation, infection, glaucoma, blurred vision, decrease in night vision, cataracts, burning

Integumentary : rash, growths, dryness, Athletes foot, thinning hair, blistering, sun sensitivity, lymphoma, acne changes, pigmented lesion, hyperpigmentation, bruising, itching, folliculitis, erythema, irritation, scars, burning

Genitourinary : frequency, urgency, burning w/ urination, lesions/sores, pain, discharge, postpartum, menopause, yeast infections w/ antibiotics

Psychiatric : nervousness, apprehension, stressful event, self-conscious, depression

Musculoskeletal : aches, cramps, pain, spasm, weakness, arthritis

Cardiovascular : palpitations, peripheral edema, varicose veins, angina, atrial fibrillation, hypertension, chest pain, heart murmur, pacemaker, deep vein thrombosis, edema

Ear/Nose/Throat : sinus infection, chronic infections (bronchitis), strep throat, vertigo, sore throat, mouth ulcers

Gastrointestinal : nausea, vomiting, diarrhea, constipation, abdominal pain, sensitive stomach

Respiratory : cough, wheezing, difficulty breathing, history of TB, shortness of breath, COPD

Endocrine : diabetes, alopecia/hair loss, hirsutism/excessive hair

Allergic/Immunologic : eczema, hay fever, asthma, hives, thyroid disease, lupus, rheumatoid arthritis

List any other diseases or conditions: _____

Pharmacy of choice: _____ **Address:** _____

Phone : _____ **Fax:** _____

What is your occupation? _____ Hobbies? _____