

# Dermatology Medical History

Name: \_\_\_\_\_ Appt Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for today's visit: \_\_\_\_\_ How Long: \_\_\_\_\_

Previous treatment: \_\_\_\_\_ Physician's Name: \_\_\_\_\_

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? \_\_\_\_\_

Do you have a history of fever blisters? No Yes If so what have you been prescribed in the past? \_\_\_\_\_

Do you have a history of herpes? No Yes

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? \_\_\_\_\_