DERMATOLOGY, P.C. MEDICAL HISTORY

Name _____ Date of Birth _____ Sex ___F ___M
Please Print - Last, First, Middle

DRUG ALLERGIES (state reaction)

☐ No Known Drug Allergies
☐ Aspirin _____
☐ Codeine _____
☐ Erythromycin _____
☐ Local Anesthetics _____
☐ Penicillin _____
☐ Sulfa _____
☐ Tetracycline _____
☐ Other, Please list drug(s) and reaction
_____
_____
_____

NON-DRUG ALLERGIES

☐ No Known Non-Drug Allergies
Do you develop skin rashes in reaction to:
☐ Medications ☐ Environment
☐ Food ☐ Other _____

CURRENT MEDICATIONS

☐ None
Please list medication(s)
_____
_____
☐ See attached list

GENERAL PERSONAL AND FAMILY HISTORY (check all that apply)

Disease	Self	Parent	Blood Relative
Arthritis	☐	☐	☐
Asthma	☐	☐	☐
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Heart Disease (Pacemaker)	☐	☐	☐
Phlebitis (blood clots)	☐	☐	☐
High Blood Pressure	☐	☐	☐
Kidney Disease	☐	☐	☐

Disease	Self	Parent	Blood Relative
Liver Disease	☐	☐	☐
Lung Disease	☐	☐	☐
Lupus	☐	☐	☐
Melanoma	☐	☐	☐
Neurological Problem	☐	☐	☐
Skin Cancer	☐	☐	☐
Other _____			

Do you need to take antibiotics prior to surgery? ☐ No ☐ Yes

MAJOR SURGERIES/ILLNESSES

(list any procedures within the last 5 years)
☐ None
☐ Artificial Joint
☐ Heart Valve
☐ Other: _____
_____
_____

REVIEW OF SYSTEMS

Do you bruise or bleed easily?	☐ No	☐ Yes
Do you have poor circulation?	☐ No	☐ Yes
Do you develop yeast infection when taking antibiotics?	☐ No	☐ Yes
Do you develop GI problems when taking antibiotics?	☐ No	☐ Yes
Do you have bloodborn infectious diseases?	☐ No	☐ Yes

DERMATOLOGICAL PERSONAL REVIEW (check all that apply)

Disorder	Active	History	N/A
Acne	☐	☐	☐
Bruise easily	☐	☐	☐
Eczema	☐	☐	☐
Hair loss	☐	☐	☐
Herpes simplex	☐	☐	☐
Herpes zoster	☐	☐	☐
Hives	☐	☐	☐

Disorder	Active	History	N/A
Pigment changes	☐	☐	☐
Psoriasis	☐	☐	☐
Scarring/Keloids	☐	☐	☐
STD/Venereal disease	☐	☐	☐
Varicose veins	☐	☐	☐
Vitiligo	☐	☐	☐
Warts	☐	☐	☐
Wound healing problem	☐	☐	☐

Other: _____

SKIN CARE

Do you regularly examine your skin for any changes? ☐ No ☐ Yes
Have you ever noticed a changing mole(s)? ☐ No ☐ Yes; Has a physician examined and treated the mole(s)? ☐ No ☐ Yes
When you are exposed to the sun, do you ☐ Tan ☐ Tan and Burn ☐ Burn
Do you regularly use sun screen when exposed to the sun? ☐ No ☐ Yes
Do you use tanning beds? ☐ No ☐ Yes; how often _____

SOCIAL HISTORY

Women: Are you pregnant ☐ No ☐ Yes; Due Date: _____
Do you smoke? ☐ No ☐ Yes; how much? _____ per day
Do you drink alcohol? ☐ No ☐ Yes; how much? _____ drinks per day

_____
Signature (Parent or Guardian, if a minor) Date

Clinical Office Review
Date/Initials

_____ _____ _____
_____ _____ _____
_____ _____ _____