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Dermatology Medical History

Patient Name: _____ Age: _____

Reason for visit: _____

Medical History: Have you ever had the following diseases or conditions: (Please check YES or NO)

	Y	N		Y	N		Y	N
Anxiety	-	-	Depression	-	-	Hypothyroidism	-	-
Arthritis	-	-	Diabetes	-	-	Leukemia	-	-
Asthma	-	-	End stage renal disease	-	-	Lung cancer	-	-
Atrial fibrillation	-	-	GERD	-	-	Lymphoma	-	-
Bone marrow transplantation	-	-	Hearing loss	-	-	Prostate cancer	-	-
Benign prostatic hyperplasia	-	-	Hepatitis	-	-	Radiation treatment	-	-
Breast cancer	-	-	Hypertension	-	-	Seizures	-	-
Colon cancer	-	-	HIV/AIDS	-	-	Stroke	-	-
COPD	-	-	High cholesterol	-	-	Other _____		
Coronary artery disease	-	-	Hyperthyroidism	-	-			

Surgical History: Have you ever had any surgeries on the following organs: (Please check YES or NO)

	Y	N		Y	N		Y	N
Appendix Removed	-	-	Heart: Mechanical valve	-	-	Ovaries removed: cyst	-	-
Bladder removed	-	-	Heart: Angioplasty	-	-	Ovaries: tubal ligation	-	-
Breast biopsy	-	-	Hip replacement (both)	-	-	Pancreas removed	-	-
Lumpectomy (both breasts)	-	-	Hip replacement (left)	-	-	Prostate biopsy	-	-
Lumpectomy (left breast)	-	-	Hip replacement (right)	-	-	Prostate cancer	-	-
Lumpectomy (right breast)	-	-	Knee replacement (both)	-	-	Prostate removal for BPH	-	-
Mastectomy (both breasts)	-	-	Knee Replacement (left)	-	-	Rectum resection APR	-	-
Mastectomy (left breast)	-	-	Knee Replacement (right)	-	-	Rectum resection low anterior	-	-
Mastectomy (right breast)	-	-	Kidney biopsy	-	-	Skin: basal cell carcinoma	-	-
Colectomy: colon cancer resection	-	-	Kidney stone removal	-	-	Skin: melanoma	-	-
Colectomy: diverticulitis	-	-	Kidney transplant	-	-	Skin: biopsy	-	-
Colectomy: inflammatory bowel	-	-	Kidney removal	-	-	Skin: squamous cell carcinoma	-	-
Colon: colostomy	-	-	Liver removal	-	-	Spleen removed	-	-
Gallbladder removal	-	-	Liver transplant	-	-	Testicle removed	-	-
Heart: biologic valve replacement	-	-	Liver shunt	-	-	Hysterectomy: fibroids	-	-
Heart: bypass surgery	-	-	Ovaries removed: endometriosis	-	-	Hysterectomy: uterine cancer	-	-
Heart: Transplant	-	-	Ovaries removed: cancer	-	-	Hysterectomy: cervical cancer	-	-
Other _____								

Skin Disease: Have you ever had any of the following conditions: (Please check YES or NO)

	Y	N		Y	N		Y	N
Acne	-	-	Dry skin	-	-	Poison ivy	-	-
Actinic keratosis	-	-	Eczema	-	-	Precancerous moles	-	-
Asthma	-	-	Flaking or itching scalp	-	-	Psoriasis	-	-
Basal cell skin cancer	-	-	Hayfever/allergies	-	-	Squamous cell skin cancer	-	-
Blistering sunburns	-	-	Melanoma	-	-	Other _____		

Skin History:

Do you wear sunscreen? (Circle) Yes No
 If yes, what SPF? _____
 Do you tan in a tanning salon? (Circle) Yes No
 Do you have a family history of melanoma? (Circle) Yes No
 If yes, which relative(s)? _____

Medications: (Please list all current medications)

Allergies: (Please list all allergies)

Social History: (Please circle all that apply)

Cigarette Smoking:

Never smoked
 Quit: former smoker
 Smoker (packs/ day ____, total yrs____)

Alcohol Use:

None
 Less than 1 drink per day
 1-2 drinks per day
 3 or more drinks per day

Sexual Activity:

Not sexually active
 Sexually active with 1 partner
 Sexually active with more than 1 partner
 Same sex partner

Race: (Circle all that apply)

White
 Black/African American
 Asian
 American Indian or Native American
 Native Hawaiian/Pacific Islander

Ethnicity: (Circle)

Hispanic/Latino
 Non-Hispanic/Latino

Preferred language

English
 Spanish
 Other

Other:

Do you drive during the day? Yes No
 Do you drive at night? Yes No
 How often do you exercise: _____
 Describe your caffeine use: _____
 Occupation and Workplace: _____
 Place of Residence: _____

Systems Review: Do you have any of the following issues: (Please check YES or NO)

	Y	N		Y	N		Y	N
Problems with bleeding	-	-	Unintentional weight loss	-	-	Neck stiffness	-	-
Problems with healing	-	-	Thyroid problems	-	-	Headaches	-	-
Problems with scarring	-	-	Sore throat	-	-	Seizures	-	-
Rash	-	-	Blurry vision	-	-	Cough	-	-
Immunosuppression	-	-	Abdominal pain	-	-	Shortness of breath	-	-
Hay fever	-	-	Bloody stool	-	-	Wheezing	-	-
Chest pain	-	-	Bloody urine	-	-	Anxiety	-	-
Fever or chills	-	-	Joint aches	-	-	Wheezing	-	-
Night sweats	-	-	Muscle weakness	-	-	Other _____	-	-

Alerts: Do you have any of the following issues: (Please check YES or NO)

	Y	N		Y	N		Y	N
HIV Positive	-	-	Allergy: adhesive	-	-	MRSA	-	-
Hep C positive	-	-	Allergy: lidocaine	-	-	Pacemaker	-	-
Epi sensitivity	-	-	Allergy: topical antibiotic	-	-	Premed prior to procedure	-	-
Taking Plavix	-	-	Artificial heart valve	-	-	Rapid heartbeat with epi	-	-
Taking Coumadin	-	-	Artificial joint (past 2 yrs)	-	-	Pregnant or planning to become pregnant	-	-
Taking Aspirin	-	-	Blood thinners	-	-	West Africa travel	-	-
Taking Xarelto	-	-	Defibrillator	-	-	Risk of Ebola	-	-

Family History: Describe any family history (only first degree relatives)

Pharmacy:

Name: _____
Street address: _____
Zip Code: _____
Phone Number: _____

Completed by: Patient
 Parent

Signature: _____ /_____/_____
Date
Print Name: _____