my dermatologist
TRUSTED SKIN CARE

Medical History

Name_____ **Date of Birth**_____

What is the reason for your visit?_____

Medications: (Please enter all current medications**)**

Allergies: (Please enter all allergies**)**

☐ Adhesive ☐ Latex ☐ Lidocaine ☐ Epinephrine ☐ Bacitracin ☐ Neosporin/neomycin

Past Medical History:

☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Bone Marrow Transplant
☐ Bleeding Disorder
☐ Breast Cancer
☐ Colon Cancer
☐ COPD
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ Kidney Disease
☐ Heartburn/ Reflux
☐ Hearing Loss
☐ Hepatitis
☐ High Blood Pressure
☐ HIV/AIDS
☐ HSV/Cold Sores
☐ High Cholesterol
☐ Thyroid Problems
☐ Leukemia
☐ Lung Cancer
☐ Lymphoma
☐ Prostate Cancer
☐ Radiation Treatment
☐ Seizures
☐ Stroke
☐ Other Cancers -_____

Other - _____

Past Surgical History: (Please enter all surgeries**)**

☐ Blood Thinners – Aspirin, Ibuprofen, NSAIDS, Coumadin, Vitamin E, Plavix
☐ Fainting or Syncope
☐ MRSA
☐ Hepatitis
☐ HIV
☐ Abnormal Scarring
☐ Pacemaker/Defibrillator
☐ Prolapsed Mitral Valve
☐ Organ Transplant
☐ Immunosuppressed
☐ Leukemia – CLL
☐ Artificial Heart Valve
☐ Artificial Joint Replacement
☐ Require antibiotics prior to a surgical procedure

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Medical History

Skin Disease History:

☐ Acne ☐ Dry Skin ☐ Melanoma
☐ Actinic Keratoses ☐ Eczema ☐ Precancerous Moles
☐ Basal Cell Cancer ☐ Flaking or Itchy Scalp ☐ Psoriasis
☐ Blistering Sunburns ☐ Hay Fever/ Allergies ☐ Squamous Cell Cancer
Other - _____

Do you wear sunscreen? ☐ Yes ☐ No If yes, what SPF?_____
Do you tan in a tanning salon? ☐ Yes ☐ No

Family History:

☐ Acne ☐ Eczema ☐ Melanoma ☐ Psoriasis
☐ Basal Cell Cancer ☐ Hay Fever/Allergies ☐ Precancerous Moles ☐ Squamous Cell Cancer
Other - _____

Social History:

Occupation_____Hobbies_____

Cigarette Smoking:

☐ Currently
☐ Former
☐ Never

Alcohol Use:

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

Do you have any of the following symptoms?

☐ No ☐Yes Fever or chills
☐ No ☐Yes Night sweats
☐ No ☐Yes Fatigue
☐ No ☐Yes Unexplained weight loss
☐ No ☐Yes Swollen lymph nodes
☐ No ☐Yes Blurry Vision/Eye irritation
☐ No ☐Yes Chronic Cough
☐ No ☐Yes Shortness of breath
☐ No ☐Yes Chest Pain
☐ No ☐Yes Abdominal Pain
☐ No ☐Yes Nausea/Vomiting

☐ No ☐Yes Diarrhea/Constipation
☐ No ☐Yes Joint Pain
☐ No ☐Yes Rash or itchy skin
☐ No ☐Yes Hives
☐ No ☐Yes Leg Swelling
☐ No ☐Yes Blood Clots
☐ No ☐Yes Easy bruising
☐ No ☐Yes Immunosuppression
☐ No ☐Yes Headaches/Dizzy
☐ No ☐Yes Depression
☐ No ☐Yes Trouble Sleeping

Women:

☐ No ☐Yes Pregnant
☐ No ☐Yes Trying to get pregnant
☐ No ☐Yes Nursing
☐ No ☐Yes Birth Control_____

☐ No ☐Yes Yeast infections
☐ No ☐Yes Hysterectomy
☐ No ☐Yes Tubal
☐ No ☐Yes Endometrialablation

_____ _____
Patient signature **Date**