

# Dermatology Medical History

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

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

Are you allergic to any medications?  YES  NO If yes, list: \_\_\_\_\_

Have you ever had problems with local anesthesia (Lidocaine/Xylocaine)?  YES  NO Any serious reaction?  YES  NO

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you take **Aspirin, Coumadin (Warfarin), Plavix**, or other **blood thinner**?  NO  YES (Rx) \_\_\_\_\_

Do you have now, or have you ever had diseases or conditions:

	YES	NO		YES	NO
<b>Pacemaker:</b>	-	-	Diabetes	-	-
<b>Artificial Heart Valves</b>	-	-	Thyroid	-	-
Irregular Heartbeat	-	-	Kidney failure/ dialysis	-	-
High Blood Pressure	-	-	<b>Hepatitis</b>	-	-
Heart Attack	-	-	If yes, what type? <input type="checkbox"/> <b>A</b> <input type="checkbox"/> <b>B</b> <input type="checkbox"/> <b>C</b>		
Heart Murmur	-	-	<b>Artificial joints</b>	-	-
Rheumatic heart disease	-	-	<b>HIV / AIDS</b>	-	-
			Convulsions, Epilepsy,		
			Seizures, or Fainting	-	-

## Skin:

Have you ever had skin cancer?  YES  NO If yes, what kind? \_\_\_\_\_  
Has anyone in your family had skin cancer?  YES  NO If yes, what kind? \_\_\_\_\_  
Do you have a history of any specific skin diseases?  YES  NO If yes, what? \_\_\_\_\_  
Do you bleed easily, or have a bleeding disorder?  YES  NO

List any other diseases or conditions: \_\_\_\_\_

List surgical procedures you have had in the last 6 months: \_\_\_\_\_

## Women –Menstrual History

Last Menstrual Period : \_\_\_\_\_ Are you pregnant?  YES  NO Are you trying to become pregnant?  YES  NO

If pregnant, OB/GYN physician: \_\_\_\_\_ weeks gestation? \_\_\_\_\_ estimated due date? \_\_\_\_\_

## Social History:

Do you drink alcohol?  YES  NO If YES, how many drinks per day? \_\_\_\_\_

Do you smoke?  YES  NO If YES, how much: \_\_\_\_\_

Have you had or have you been exposed to HIV / AIDS or Hepatitis C?  YES  NO

What is your occupation? \_\_\_\_\_

Who is your Primary Care Physician (pedi, family med, internal med)? \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient / Legal Guardian

\_\_\_\_\_  
Date