

Dermatology Medical History

Patient Name: _____ Date: ____/____/____

Select any of the following medical conditions that you currently have:

- | | |
|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypercholesterolemia |
| <input type="checkbox"/> Atrial Fibrillation(Irregular Heart Beat) | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> GERD | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Valve Replacement |
| <input type="checkbox"/> Other _____ | |

List Past Surgical Procedures: _____

Have You Had Any of the Following Skin Conditions:

- | | |
|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Flaky or Itchy Skin |
| <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> Hay Fever/Allergies |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Poison Ivy |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Precancerous Moles |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Squamous Cell Skin Cancer |

Do You Wear Sunscreen? Yes No If yes what SPF? _____
Do You Tan In A Tanning Salon? Yes No

Family History

Do you have a family history of Melanoma? Yes No
If yes, which relative?

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Aunt |
| <input type="checkbox"/> Father | <input type="checkbox"/> Nephew |
| <input type="checkbox"/> Sister | <input type="checkbox"/> Niece |
| <input type="checkbox"/> Brother | <input type="checkbox"/> Grandmother |
| <input type="checkbox"/> Daughter | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Son | <input type="checkbox"/> Grandson |
| <input type="checkbox"/> Uncle | <input type="checkbox"/> Granddaughter |

Surgical History

Have you ever had difficulty stopping bleeding? Yes No
Do you require Antibiotics prior to a surgical procedure? Yes No
Have you had an artificial joint replacement? Yes No When _____ Where _____
Do you have an artificial heart valve? Yes No
Do you have a pacemaker? Yes No
Do you have a defibrillator? Yes No
Are you pregnant or currently trying to get pregnant? Yes No

MEDICATIONS:

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

ALLERGIES:

1. _____ 2. _____ 3. _____ 4. _____

Social History:

Do you drink alcohol? Yes No Do you smoke? Yes No Do you use IV drugs? Yes No

<u>Check all that apply</u>	<u>YES</u>	<u>NO</u>
pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
artificial joints	<input type="checkbox"/>	<input type="checkbox"/>
artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>
premedication prior to procedures	<input type="checkbox"/>	<input type="checkbox"/>
allergy to adhesive	<input type="checkbox"/>	<input type="checkbox"/>
allergy to topical antibiotic ointments	<input type="checkbox"/>	<input type="checkbox"/>
blood thinners	<input type="checkbox"/>	<input type="checkbox"/>
pregnancy or planning a pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
allergy to lidocaine	<input type="checkbox"/>	<input type="checkbox"/>
rapid heart beat with epinephrine	<input type="checkbox"/>	<input type="checkbox"/>
yeast infections with antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
GI upset with antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Joint Aches	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
problems with bleeding	<input type="checkbox"/>	<input type="checkbox"/>
problems with healing	<input type="checkbox"/>	<input type="checkbox"/>
problems with scarring (hypertrophic or keloid)	<input type="checkbox"/>	<input type="checkbox"/>
immunosuppression	<input type="checkbox"/>	<input type="checkbox"/>
changing mole	<input type="checkbox"/>	<input type="checkbox"/>
anxiety	<input type="checkbox"/>	<input type="checkbox"/>
chest pain	<input type="checkbox"/>	<input type="checkbox"/>
depression	<input type="checkbox"/>	<input type="checkbox"/>
fever or chills	<input type="checkbox"/>	<input type="checkbox"/>
headaches	<input type="checkbox"/>	<input type="checkbox"/>

Completed by:

- Patient **Signature of Patient** _____ Date ____/____/____
- Medical Assistant **Initials** _____
- Other **Signature and relationship to patient** _____ Date ____/____/____