Patient Label

DERMATOLOGY

MEDICAL HISTORY FORM

Internal diseases and medication side effects can manifest themselves on the skin. Therefore, it is important for us in dermatology to know your other medical conditions, medications and allergies to medications. Please fill out this form to the best of your knowledge.

Did a doctor recommend that you see a dermatologist? No Yes: Dr.____

Which pharmacy do you prefer? __________________________________

General Medical History:

Have you ever been PERSONALLY diagnosed with any of the following?

□ Heart Disease
□ Heart murmurs
□ Arrhythmia
□ Bleeding disorder (explain below)
□ Artificial heart valves
□ Pacemaker with Defibrillator
□ Pacemaker without Defibrillator
□ High blood pressure
□ High cholesterol
□ Diabetes (high blood sugar)
□ Artificial joints
□ Kidney disease, Dialysis
□ Hepatitis (what type B or C) or other liver disease (explain below)
□ Organ transplant (what type)
□ AIDS or HIV
□ Seizures
□ Abnormal scars or keloids
□ Abnormal/atypical moles removed from skin
□ Non-melanoma skin cancer (Basal Cell Cancer or Squamous Cell Cancer)
□ Melanoma skin cancer (when, body area, stage, lymph nodes removed? Explain below)
□ Herpes (circle: genital or mouth)
□ Psoriasis
□ Rheumatoid Arthritis
□ Lupus, dermatomyositis or other autoimmune disease \ (explain below)
□ Intravenous drug use
□ Emphysema or COPD
□ Asthma
□ Hay fever (allergic rhinitis), environmental allergies

Use this space for explanations AND other medical conditions (PLEASE PRINT):

____

____

____

General Surgical History (PLEASE PRINT):

____

____

Female patients:

Are you breastfeeding now? Y N Are you pregnant now, or plan to be pregnant soon? Y N

TURN OVER FOR PAGE 2

Patient Label

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Family History:

Is a blood relative affected by any of the following?

☐ Adopted, family history unknown

☐ Basal Cell ☐ Squamous Cell ☐ Melanoma

Which relative: ____________________________

☐ Psoriasis ☐ Lupus ☐ Rheumatoid Arthritis ☐ Thyroid Disease

Which relative: ____________________________

☐ Allergies, Asthma, Eczema

Which relative: ____________________________

Social History:

Do you use alcohol?	Y	N
Do you use caffeine?	Y	N
Have you used any tobacco product in the past 30 days?	Y	N
Are you a former smoker? If so, what year did you quit: _____	Y	N
Do you have concerns about your safety?	Y	N
Has anyone hurt you in any way?	Y	N

Allergies to medication (check box if allergic AND list reaction):

☐ Lidocaine, reaction: _______________

☐ Epinephrine, reaction: ____________

☐ Betadine/Iodine, reaction:_________

☐ Codeine, Morphine, Narcotics

reaction:________________________

☐ Penicillin, reaction: _______________

☐ Sulfa, reaction:___________________

☐ Other antibiotics

list name and reaction:

____

____

☐ Creams/Ointments list & reaction:

____

____

☐ Other medication allergies

(PRINT medication and reaction):

____

Medications (Check box and use line for explanations):

☐ Aspirin (strength: ______________)

☐ Arthritis medications

(list: ________________________)

☐ Coumadin/Warfarin

☐ Plavix

☐ Other blood thinners

(list: ________________________

____________________________)

☐ Other prescription medications (PRINT names):

____

____

____

____

☐ Over-the-counter medications, supplements (PRINT names):

____

____

Name of person filling out this form ____

Signature of person filling out this form____ **today's date**______________