

**DERMATOLOGY MEDICAL HISTORY FORM** (rev 8/6/05)

Name \_\_\_\_\_ Age \_\_\_\_\_ Prefer to be called \_\_\_\_\_

**REFERRED BY:** \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_\_

**General Medical History:** Do you have or have you ever had any of the following?

- |  |   |   |
|--|---|---|
| Y N Pacemaker or defibrillator   | Y N Kidney problem (what type?)   | Y N HIV or AIDS                                       |
| Y N Asthma   | Y N Tuberculosis  | Y N Hepatitis (what type?) A B C                      |
| Y N Hayfever, seasonal allergies   | Y N Epilepsy or seizures  | Y N Liver cirrhosis or other liver problems           |
| Y N Diabetes, controlled with (circle):<br>diet, medication, insulin   | Y N Arthritis (if yes, osteoarthritis,<br>rheumatoid, or psoriatic?)          | Y N Nausea, vomiting, or diarrhea with<br>antibiotics |
| Y N Lupus  | Y N Osteoporosis  | Y N Herpes-(circle) genital or mouth                  |
| Y N Overgrown scars or keloids   | Y N Thyroid problem (what type?)  | Y N Genital warts                                     |
| Y N High cholesterol   | Y N Organ transplant (what type?)   | Y N Blood clots in legs (DVT)                         |
| Y N High blood pressure  | Y N Crohn's disease or ulcerative colitis                                     | Y N Anemia  |
| Y N Stroke   | Y N Reflux/ GERD/ Heartburn or peptic ulcers                                  | Y N Blood transfusion (when)                          |
| Y N Heart attack   | Y N Emphysema or COPD   | Y N Bleeding disorder                                 |
| Y N Angina/ Coronary artery disease  | Y N Fainting with injections  | Y N Anxiety   |
| Y N Heart murmur or heart valve problem  | Y N Melanoma  | Y N Depression  |
| Y N Have you been told to take antibiotics<br>before dental procedures due to a heart<br>murmur, heart valve, or artificial joint? | Y N Basal cell or squamous cell skin cancer<br>(where on body, when treated?) | Y N Cancer (what type, how treated, and<br>when?)     |

**Surgeries:**

- |                             |  |                          |
|-----------------------------|--|--------------------------|
| Y N Heart valve replacement | Y N Artificial joint (If yes, which one & when?) | Y N Heart bypass surgery |
|-----------------------------|--|--------------------------|

**Female Patients:**

- |   |  |
|---|--|
| Y N Are you pregnant or breastfeeding? If not, method of birth control: _____ | Y N Are you contemplating pregnancy?<br>If yes, when: _____      |
| Y N Tubal ligation (tubes tied)   | Y N Hysterectomy (if yes, uterus only or<br>uterus and ovaries?) |

**Other Medical Problems or Surgeries:** \_\_\_\_\_

**Allergies to medications** and type of allergic reaction (example: hives, difficulty breathing, swelling) \_\_\_\_\_

**Medications** (Prescription, Non-Prescription, Vitamins, Herbs): \_\_\_\_\_

**Skin Type:** If 1<sup>st</sup> exposed to the sun in the summer without sunscreen, would you: 1. always burn, never tan 2. always burn, sometimes tan  
3. sometimes burn, always tan gradually 4. burn minimally, always tan well 5. rarely burn, tan profusely 6. never burn, deeply pigmented

**Social History:** Do you smoke or use tobacco? Y N Do you drink alcohol? Y N Number per day \_\_\_\_\_ per week \_\_\_\_\_ per year \_\_\_\_\_  
Marital status: \_\_\_\_\_ Children: \_\_\_\_\_ Hobbies: \_\_\_\_\_ Occupation: \_\_\_\_\_ Indoors/ Outdoors

**Family History:** Circle any conditions affecting a blood relative. Specify who is affected below the circle.

Melanoma Basal cell or squamous cell skin cancer Psoriasis Eczema Hayfever or allergies Asthma Acne

**Signature of person filling out this form** \_\_\_\_\_ **Today's date** \_\_\_\_\_ **STOP HERE.**


Updated \_\_\_\_\_