Affiliated Dermatologists, Inc.
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Dermatology Medical History

Name: _____ Date of Birth: _____

Reason for today's visit: _____

Are you allergic to any medications? ☐ YES ☐ NO If yes, list below:

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

Do you develop skin rashes in reaction to: ☐ Medications ☐ Food ☐ Environment ☐ Bandages ☐ Topical Neosporin

Other: _____

Have you had dental anesthesia (Novocaine)? ☐ YES ☐ NO Did you have a bad reaction? ☐ YES ☐ NO

Have you had a COVID-19 vaccination? ☐ YES 1st Date: _____ 2nd Date: _____ 3rd Date: _____ ☐ NO

Do you have now, or have you ever had diseases or conditions of: (Please check: YES or NO)

LUNGS:			CARDIOVASCULAR			OTHER SYSTEMIC:		
Emphysema	☐ YES	☐ NO	High Blood Pressure	☐ YES	☐ NO	Diabetes	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Heart Attack	☐ YES	☐ NO	Thyroid	☐ YES	☐ NO
Shortness of Breath	☐ YES	☐ NO	Heart Murmur	☐ YES	☐ NO	Kidney	☐ YES	☐ NO
			Irregular Heartbeat	☐ YES	☐ NO	Dialysis	☐ YES	☐ NO
			Phlebitis	☐ YES	☐ NO	Bladder	☐ YES	☐ NO
			Blood Clots	☐ YES	☐ NO	Arthritis	☐ YES	☐ NO
			Pacemaker	☐ YES	☐ NO	Joint Deformity	☐ YES	☐ NO
						Artificial Joint	☐ YES	☐ NO
						Epilepsy/Seizures	☐ YES	☐ NO

List any other diseases or conditions: _____

_____

List surgical procedures you have had: _____

_____

SKIN:

Have you had skin cancer? ☐ YES ☐ NO Type: _____

Has anyone in your family had skin cancer? ☐ YES ☐ NO Type: _____

Do you have history of any specific skin disease? ☐ YES ☐ NO If yes: _____

Do you have problems with healing? ☐ YES ☐ NO

Do you develop keloids (scars) after surgery? ☐ YES ☐ NO

Do you bleed easy? ☐ YES ☐ NO

SOCIAL HISTORY:

Do you drink alcohol? ☐ YES ☐ NO If yes, how many drinks per day? _____

Do you use IV drugs? ☐ YES ☐ NO If yes, what? _____

Do you smoke? ☐ YES ☐ NO If yes, how many? _____

Have you had or have you been exposed to HIV (AIDS)? ☐ YES ☐ NO

What is your occupation? _____ Hobbies? _____

(Women) Are you pregnant? ☐ YES ☐ NO Due Date: _____ Nursing? ☐ YES ☐ NO

Completed by: ☐ Patient ☐ Guardian/Parent Patient Signature: _____ Date: _____