

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: _____ NO

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

LUNGS:

Emphysema YES NO
Asthma YES NO
Shortness of Breath YES NO

CARDIOVASCULAR

High Blood Pressure YES NO
Heart Attack YES NO
Heart Murmur YES NO
Irregular Heartbeat YES NO
Phlebitis YES NO
Blood Clots YES NO
Pacemaker YES NO

OTHER SYSTEMIC:

Diabetes YES NO
Thyroid YES NO
Kidney YES NO
Dialysis YES NO
Bladder YES NO
Arthritis 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: _____