my dermatologist
TRUSTED SKIN CARE

Medical History

Name_____ Date of Birth_____

What is the reason for your visit?_____

_____

_____

Medications: (Please enter all current medications)

_____

_____

_____

_____

Allergies: (Please enter all allergies)

_____

_____

☐Adhesive, ☐Latex, ☐Lidocaine, ☐Epinephrine, ☐Bacitracin, ☐Neosporin/neomycin,

Past Medical History:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bone Marrow Transplant
- ☐ Bleeding disorder
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Kidney disease
- ☐ Heartburn/reflux
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood pressure
- ☐ HIV/AIDS
- ☐ HSV/Cold sores
- ☐ High Cholesterol
- ☐ Thyroid Problems
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other Cancers -

_____

_____

_____

Other _____

Past Surgical History: (Please enter all surgeries)

_____

_____

- ☐ Blood thinners - aspirin, ibuprofen, NSAIDS, coumadin, vitamin E, Plavix,
- ☐ Fainting or syncope
- ☐ MRSA
- ☐ Hepatitis
- ☐ HIV
- ☐ Abnormal scarring
- ☐ Pacemaker/Defibrillator
- ☐ Prolapsed mitral valve
- ☐ Organ transplant
- ☐ Immunosuppressed
- ☐ Leukemia - CLL
- ☐ Artificial heart valve
- ☐ Artificial joint replacement
- ☐ Require antibiotics prior to a surgical procedure.

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Medical History

Skin Disease History:

☐ Acne	☐ Dry Skin	☐ Melanoma
☐ Actinic Keratoses	☐ Eczema	☐ Precancerous Moles
☐ Basal Cell Cancer	☐ Flaking or Itchy Scalp	☐ Psoriasis
☐ Blistering Sunburns	☐ Hay Fever/Allergies	☐ Squamous Cell Cancer

Other _____

Do you wear Sunscreen? ☐Yes ☐No If yes, what SPF? _____

Do you tan in a tanning salon? ☐Yes ☐No

Family History:

☐ Acne	☐ Hay Fever/Allergies	☐ Psoriasis
☐ Basal Cell Cancer	☐ Melanoma	☐ Squamous Cell Cancer
☐ Eczema	☐ Precancerous Moles	

Other _____

Social History:

Occupation_____ **Hobbies**_____

Cigarette Smoking:

☐Currently smokes
☐Has smoked in the past
☐Never smoked
☐Former smoker

Alcohol Use:

☐None
☐Less than 1 drink per day
☐1-2 drinks per day
☐3 or more drinks per day

Do you have any of the following symptoms?

☐No ☐Yes	Fever or chills	☐No ☐Yes	Diarrhea/constipation
☐No ☐Yes	Night sweats	☐No ☐Yes	Joint pain
☐No ☐Yes	Fatigue	☐No ☐Yes	Rash or itchy skin
☐No ☐Yes	Unexplained weight loss	☐No ☐Yes	Hives
☐No ☐Yes	Swollen lymph nodes	☐No ☐Yes	Leg swelling
☐No ☐Yes	Blurry vision/Eye irritation	☐No ☐Yes	Blood clots
☐No ☐Yes	Chronic cough	☐No ☐Yes	Easy bruising
☐No ☐Yes	Shortness of breath	☐No ☐Yes	Immunosuppression
☐No ☐Yes	Chest pain	☐No ☐Yes	Headaches/Dizzy
☐No ☐Yes	Abdominal pain	☐No ☐Yes	Depression
☐No ☐Yes	Nausea/Vomiting	☐No ☐Yes	Trouble sleeping

WOMEN:

☐No ☐Yes	Pregnant	☐Yeast infections
☐No ☐Yes	Trying to get pregnant	☐Hysterectomy
☐No ☐Yes	Nursing	☐Tubal
☐No ☐Yes	Birth control_____	☐Endometrial ablation

_____ _____

Signature of patient/guardian **Date**