DERMATOLOGY MEDICAL HISTORY FORM

Name____ Age_______ Prefer to be called________________________

Height________ Weight________ **Did a doctor recommend that you see a dermatologist?** No Yes, Dr.________________

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

Y N Pacemaker or defibrillator*
Y N Asthma
Y N Hayfever, seasonal allergies
Y N Eczema
Y N Psoriasis
Y N Diabetes, controlled with (circle): diet, medication, insulin
Y N High cholesterol
Y N High blood pressure
Y N Stroke
Y N Heart attack
Y N Angina/Coronary artery disease
Y N Congestive heart failure
Y N Heart murmur or heart valve problem
Y N Have you been told to take antibiotics before dental procedures due to a heart murmur, heart valve, or artificial joint?

Y N Acne &/or Rosacea (circle)
Y N Scleroderma
Y N Overgrown scars or keloids
Y N Kidney problems (what type?)
Y N Epilepsy or seizures
Y N Crohn's disease or ulcerative colitis
Y N Arthritis (if yes, osteoarthritis, rheumatoid, or psoriatic?)
Y N Thyroid problem (what type?)
Y N Osteoporosis
Y N Organ transplant (what type?)
Y N Fibromyalgia
Y N Reflux/GERD/Heartburn or peptic ulcers
Y N Emphysema or COPD
Y N Melanoma
year_____ location______________
Y N Basal cell or squamous cell skin cancer
year_____ location______________

Y N Sarcoid
Y N HIV or AIDS
Y N Hepatitis (what type?) A B C
Y N Multiple sclerosis
Y N Lupus-(circle) Systemic or Discoid
Y N Liver cirrhosis or other liver problems
Y N Herpes-(circle) genital or mouth
Y N Genital warts
Y N Blistering sunburns
Y N Tuberculosis
Y N Blood clots in legs (DVT)
Y N Anemia-(circle) Iron or Folate
Y N Blood transfusion (when) ___________
Y N Bleeding disorder, type _____________
Y N Anxiety
Y N Depression or other psychological condition, type_________________
Y N Cancer (what type, how treated, and when?)

Surgeries:

Y N Abnormal moles proven on biopsy
Y N Heart valve replacement

Y N Artificial joint *
(If yes, which one & when?)

Y N Gallbladder removed
Y N Heart bypass surgery

Female Patients:

Y N Are you pregnant or breastfeeding?
If not, method of birth control
____

Y N Are you planning to get pregnant?
If yes, when:_______________
Y N Hysterectomy (if yes, uterus only or uterus and ovaries?)

Y N Prone to yeast infections with antibiotics
Y N Tubal ligation (tubes tied)

Other Medical Problems or Surgeries:____

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

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Medications (Prescription, Non-Prescription, Vitamins, Herbs):____

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Skin Type: If 1st 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:_____________ # of Children:___________ Hobbies:_________________________ Occupation/School:_________________

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

Melanoma Basal cell or squamous cell skin cancer Breast Cancer Psoriasis Eczema

Hayfever or allergies Asthma Acne Lupus Sarcoid

Signature of person filling out this form____ **Today's date**__________________

Updated____