Dermatology Medical History

MR #________________

Today's Date: ______/______/______

Last Name: ________________ First Name: ________________ MI:______ DOB: _____/_____/_____

Referring Doctor:________________________ Primary Care Doctor: ________________________

Reason(s) for Today's Visit: ____ Age: ______

List all Allergies: ____ Male ☐ Female ☐

List current medications: (include prescriptions, creams, over-the counter, vitamins, supplements, herbals)

________________ ________________ ________________ ________________

________________ ________________ ________________ ________________

Have you ever had skin cancer or abnormal moles? Circle type(s)

None Atypical (Dysplastic) mole Basal cell Squamous cell Melanoma Unknown

Past Medical History: Check all that apply

☐ Eczema ☐ Asthma ☐ Psoriasis ☐ Organ Transplant ☐ Lupus ☐ Cancer ☐ Blood Clots

☐ Liver Disease ☐ Kidney Disease ☐ Rheumatoid Arthritis ☐ Pacemaker ☐ Stomach Ulcers

☐ Crohn's/UC ☐ Stroke/CVA ☐ Heart Disease ☐ High Blood Pressure ☐ Thyroid Disease

☐ Lung Disease ☐ Headaches ☐ Depression ☐ Glaucoma ☐ Diabetes ☐ HIV/Hepatitis

☐ Seizures ☐ Other (Explain) ________________________________

Previous Surgeries:

	Year		Year
________________	______	________________	______
________________	______	________________	______

Social History:

	Yes	No	
Do you smoke?	☐	☐	If yes, how much? ____________
Do you drink alcohol?	☐	☐	If yes, ______ drinks per day
Do you use recreational drugs?	☐	☐	If yes, type ____________

Who lives in your household? ________________________________

What is your occupation? ________________________________

For Women Only: Age when periods began? _____ Regular? Yes ☐ No ☐ Date of last period ______

Are you pregnant? Yes ☐ No ☐ Due Date __________ Are you Nursing? Yes ☐ No ☐

Updated by:	____________ Patient (Initials)	___/___/___ Date	____________ Physician (Initials)	___/___/___ Date
Updated by:	____________ Patient (Initials)	___/___/___ Date	____________ Physician (Initials)	___/___/___ Date
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Review of Systems: (circle any that you have been experiencing)

General:	None	fever	chills	sweats	weight loss/ gain	fatigue
Eyes:	None	pain	vision change	tearing	dryness	itching
ENT/Mouth:	None	headache	mouth sores	hearing loss	vertigo	nosebleeds
Cardiovascular:	None	chest pain	palpitations	fainting	leg swelling	
Respiratory:	None	cough	wheezing	shortness of breath		
Gastrointestinal:	None	nausea	vomiting	heartburn	diarrhea	constipation
			blood in stools	jaundice	loss of appetite	trouble swallowing
Urinary:	None	frequency	urgency	pain	nighttime urination	
Musculoskeletal:	None	joint pain/ swelling	back pain	muscle pain	weakness	
Skin:	None	itch rash	dryness	mole change		
Endocrine:	None	excessive thirst	hot flashes	hair loss/ gain	intolerance to heat/cold	
Blood/Lymph:	None	bruising	bleeding	swollen glands		
Neurological:	None	dizziness	numbness	tremors	loss of memory	
Psychiatric:	None	anxiety	depression	suicidal thoughts		
Allergic:	None	hives	reactions to foods/drugs/insects			

Family History:

	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Mother	__________	________________	________	________________________
Father	__________	________________	________	________________________

Number of Siblings: _____ Number living: _____ Ages: ____________________

Number of Children: _____ Number living: _____ Ages: ____________________

Do any blood relatives have or had:

☐ Melanoma ☐ Basal/Squamous Cell Carcinoma ☐ Severe Acne ☐ Eczema ☐ Psoriasis

☐ Liver Disease ☐ Stroke ☐ Heart Disease ☐ Leukemia ☐ Blood Clots

☐ Arthritis ☐ Kidney Disease ☐ Asthma ☐ Lupus

☐ Non-Skin Cancer: Type ________________ ☐ Other ________________________

With whom may we discuss your protected medical information? List names and relationships

____

Completed by: ☐ Patient ☐ Guardian ______________________________ ____/____/____

Signature of Patient or Guardian Date

☐ MA ________
Initials