

Name: \_\_\_\_\_

Chart: \_\_\_\_\_

DOB: \_\_\_\_\_

Date: \_\_\_\_\_

### Dermatology Medical History

List all **medications** you are currently taking (including prescriptions, over-the-counter meds, vitamins, herbals, etc.):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

List all **allergies** to medications:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

#### Review of Systems

##### Skin (please √)

- Have you ever had a skin cancer? \_\_\_\_\_
- Do you have a family history of skin cancer? \_\_\_\_\_
- Do you bleed easily? \_\_\_\_\_
- Do you develop keloids? \_\_\_\_\_
- Do you have problems with healing? \_\_\_\_\_

Type? \_\_\_\_\_

Type? \_\_\_\_\_

List any **skin conditions/diseases**: \_\_\_\_\_

#### Other Systems

Do you have: (please √)

- Diabetes \_\_\_\_\_
- Thyroid Disease \_\_\_\_\_
- Kidney Disease \_\_\_\_\_
- Liver Disease \_\_\_\_\_
- Heart Disease \_\_\_\_\_

- Artificial Joint \_\_\_\_\_
- Pacemaker \_\_\_\_\_
- Defibrillator \_\_\_\_\_
- Artificial Heart Valve \_\_\_\_\_
- HIV/AIDS \_\_\_\_\_

List any other **medical conditions/diseases**: \_\_\_\_\_

List any **surgical problems** during the last 6 months: \_\_\_\_\_

Women	Yes	No
Are you <b>pregnant</b> ?	_____	_____
Are you <b>nursing</b> ?	_____	_____

#### Social History

Do you drink alcohol? \_\_\_\_\_

Do you smoke? \_\_\_\_\_

Completed by: Patient \_\_\_\_\_ Guardian \_\_\_\_\_ Medical Asst. \_\_\_\_\_

	Updated	Initials
_____ Patient/Guardian Signature	_____	_____
_____ Date	_____	_____
_____ Reviewed By	_____	_____
_____ Date	_____	_____