

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 pregnant ? | _____ | _____ |
| Are you nursing ? | _____ | _____ |

Social History

Do you drink alcohol? _____

Do you smoke? _____

Completed by: Patient _____ Guardian _____ Medical Asst. _____

| | Updated | Initials |
|-------|---------|----------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Patient/Guardian Signature Date

Reviewed By Date