dermatology CONSULTANTS

Medical History Form

Please fill out both sides of the questionnaire

Name _____ Date of birth _____ Age _____

How did you hear about us? ☐ Internet ☐ Phone book ☐ Friend ☐ Medical provider – name _____

What is the reason for your visit today? How long has condition been present? Prior treatments?

_____

_____

List current medications (prescription and over-the-counter): ☐ None

_____

_____

Please attach separate list if needed

List allergies to medications: ☐ None

_____

_____

Problems with the following? ☐ Latex ☐ Local anesthetics ☐ Epinephrine ☐ Tape/band-aids ☐ Topical antibiotics

Are you on blood thinners? ☐ No ☐ Aspirin ☐ Ibuprofen ☐ Coumadin ☐ Vit E ☐ Plavix ☐ Other: _____

Do you need pre-medication with antibiotics for dental work or surgery? ☐ Yes ☐ No

Please check if you have a personal or family history of the following skin conditions:

	PERSONAL HISTORY	**FAMILY HISTORY** *(please list relation)*
Eczema	☐ _____	☐ _____
Psoriasis	☐ _____	☐ _____
Acne	☐ _____	☐ _____
Abnormal scars	☐ _____	☐ _____
Abnormal moles	☐ _____	☐ _____
Precancerous growths	☐ _____	☐ _____
Skin cancer (list type)	☐ _____	☐ _____

How does your skin react to sun exposure? ☐ Always burn, never tan ☐ Tan well, rarely burn ☐ Burn easily, then tan a little ☐ Never burn ☐ Tan slowly, sometimes burn

Do you now or in the past use tanning beds routinely? ☐ No ☐ Yes Do you tan outdoors? ☐ No ☐ Yes

Do you get a rash or other skin reaction to the sun? ☐ No ☐ Yes Do you wear sunscreen? ☐ No ☐ Yes

Do you do any of the following to protect your skin? ☐ Wear a hat ☐ Wear sun protective clothing ☐ Wear sunglasses ☐ Avoid mid-day sun

Do you take multivitamins? ☐ No ☐ Yes If yes, do you take extra vitamin D? _____

Please turn over and complete reverse side

Do you have now or in the past any of the following? If yes, please explain.

☐ No ☐ Yes Chronic fever or sweats _____
☐ No ☐ Yes Unexplained weight change _____
☐ No ☐ Yes Weakness/fatigue _____
☐ No ☐ Yes Cancer (other than skin) _____
☐ No ☐ Yes Headaches _____
☐ No ☐ Yes Eye problems _____
☐ No ☐ Yes Cold sores/mouth sores _____
☐ No ☐ Yes Hayfever _____
☐ No ☐ Yes Asthma _____
☐ No ☐ Yes Other breathing problems _____
☐ No ☐ Yes Hives _____
☐ No ☐ Yes High blood pressure _____
☐ No ☐ Yes High cholesterol _____
☐ No ☐ Yes Heart valve disease _____
☐ No ☐ Yes Pacemaker or defibrillator _____
☐ No ☐ Yes Nerve disease or stroke _____
☐ No ☐ Yes Leg swelling or varicose veins _____
☐ No ☐ Yes Gastrointestinal disease _____
☐ No ☐ Yes Hepatitis _____
☐ No ☐ Yes Kidney disease _____
☐ No ☐ Yes Thyroid disease _____
☐ No ☐ Yes Diabetes _____
☐ No ☐ Yes Arthritis or artificial joints _____
☐ No ☐ Yes Bleeding or clotting disorder _____
☐ No ☐ Yes Fainting _____
☐ No ☐ Yes Mental health disorder _____
☐ No ☐ Yes HIV or immunocompromised _____
☐ No ☐ Yes Organ transplants (list year) _____

Do you have any medical problems or conditions that are not listed above? _____

_____

SOCIAL HISTORY

What is your occupation? _____ If student, what is your school and grade? _____

What are your hobbies? _____

Do you drink alcohol? ☐ No ☐ Yes If yes, how many drinks per day? _____

Do you smoke cigarettes? ☐ No ☐ Yes If yes, how many per day? _____

WOMEN ONLY

Are you on any birth control? ☐ No ☐ Yes, type _____
Have you had a hysterectomy, tubal ligation or endometrial ablation? ☐ No ☐ Yes, type _____
Are you pregnant? ☐ No ☐ Yes, due date? _____
Trying to become pregnant? ☐ No ☐ Yes
Are you nursing? ☐ No ☐ Yes
Frequent yeast infections? ☐ No ☐ Yes

CHILDREN UNDER 10

Premature birth? ☐ No ☐ Yes
Food allergies? ☐ No ☐ Yes
Concerns with growth? ☐ No ☐ Yes
Developmental concerns? ☐ No ☐ Yes

Signature (parent or guardian if patient is under 18)	Date
Printed name (if filled out by someone other than patient)	Relationship
Signature of physician	Date