

MEDICAL HISTORY FORM

In regard to your single most important skin problem, please answer the following questions:

(The dermatologist may not be able to address all of your skin problems during your initial visit.)

Please briefly describe your skin problem: _____

List parts of your body affected: _____

How long have you had the problem: _____

List symptoms and how bad they are (itch,burn,sting,hurt,other,etc.) _____

List treatments and whether they helped: _____

Current Medications: _____

Drug allergies: _____

Are you pregnant or planning a pregnancy or currently nursing? Yes No

Explain: _____

If pregnant, how many weeks _____ Any medical complications? _____

Do you take aspirin on a regular basis? Yes No

Occupation: _____

FAMILY HISTORY

- | | | | |
|--------------------------------------|------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Cancer | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Other: _____ |

REVIEW OF SYSTEMS AND PAST MEDICAL HISTORY

- | | |
|---|--|
| <input type="checkbox"/> Psoriasis
<input type="checkbox"/> Keloid/bad scarring
<input type="checkbox"/> Skin cancer
<input type="checkbox"/> Eczema
<input type="checkbox"/> Hair Loss
<input type="checkbox"/> Progressive <input type="checkbox"/> Recent
<input type="checkbox"/> Dry Skin
<input type="checkbox"/> Itchy skin
<input type="checkbox"/> Oily facial skin
<input type="checkbox"/> Acne
<input type="checkbox"/> Cold sores/herpes
<input type="checkbox"/> Dandruff
<input type="checkbox"/> Heart problems
<input type="checkbox"/> Leg swelling
<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Heart valve problems
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Lung problems(Including TB exposure)
<input type="checkbox"/> Gastrointestinal problems
<input type="checkbox"/> Eye problems/glaucoma/cataracts
<input type="checkbox"/> Hepatitis/liver problems/jaundice
<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Kidney problem
<input type="checkbox"/> Headaches <input type="checkbox"/> Migraines
<input type="checkbox"/> Seizures/neurologic problems
<input type="checkbox"/> Depression/psychiatric issues | <input type="checkbox"/> Anemia
<input type="checkbox"/> Bleeding easily or blood clots
<input type="checkbox"/> Internal Cancer. Type? _____
<input type="checkbox"/> Previous Surgery: _____
<input type="checkbox"/> Recent Fever
<input type="checkbox"/> X-Ray or radiation exposure
<input type="checkbox"/> Recent weight loss or gain
<input type="checkbox"/> Recent weakness/tiredness
<input type="checkbox"/> Recent cold or flu
<input type="checkbox"/> Recent Sore Throat
<input type="checkbox"/> Recent Hospitalization
Reason _____
<input type="checkbox"/> Frequent sunburns
<input type="checkbox"/> Sun sensitivity
<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Lupus
<input type="checkbox"/> Joint pain
<input type="checkbox"/> Diabetes/high blood sugar
<input type="checkbox"/> HIV+
<input type="checkbox"/> AIDS Risk(blood transfusions, multiple partners, homosexual activity, IV drug use)
<input type="checkbox"/> Easy fainting
<input type="checkbox"/> Other _____ |
|---|--|

Females

- Irregular Menses
 Present Birth control use
 Postmenopausal
 Increased facial / body hair

For all patients:

Non skin related problems should be brought to the attention of your primary care doctor. If you do not have a primary care doctor, please ask us and we will refer you to one.

HABITS	
	Count
Cigarettes/day	
Alcohol Oz/week	
Tanning/week	
Coffee/Tea cup/day	
Regular Exercise/week	
Sunscreen use	

Do we have your permission to:

Send you a postcard regarding benign biopsy results? Yes No

Discuss your medical condition with a member of your household? Yes No

If yes whom: _____ Relationship _____

Patient Signature _____ Date _____