

Name _____
 Chart _____
 DOB _____

Dermatology Medical History

Date _____

Scan back of form

Primary Doctor/Clinic: _____ Referred by your doctor? Yes / No

Reason for today's visit: _____

Do you have cosmetic concerns? Yes / No Circle: Botox, Restylane, Juvederm, Veins, Hair removal, Wrinkles, Brown spots

Allergies: _____

Medications: _____

<u>Skin Conditions and Social History</u>	<u>Yes</u>	<u>No</u>	<u>Past Surgeries:</u>	<u>Yes</u>	<u>No</u>
Have you had skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker / Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Basal Cell Carcinoma?	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>
Squamous Cell Carcinoma?	<input type="checkbox"/>	<input type="checkbox"/>	Heart valve replacement	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant	<input type="checkbox"/>	<input type="checkbox"/>
Have you had abnormal / dysplastic moles?	<input type="checkbox"/>	<input type="checkbox"/>	Tubal ligation	<input type="checkbox"/>	<input type="checkbox"/>
Have you had pre-cancerous Actinic Keratoses?	<input type="checkbox"/>	<input type="checkbox"/>	List other surgeries _____		
List any other skin conditions you have: (Examples: Eczema, Psoriasis, Acne, Rosacea, Vitiligo)					
			<u>Family Medical Problems:</u>	<u>Yes</u>	<u>No</u>
Do you use sunscreen? SPF _____	<input type="checkbox"/>	<input type="checkbox"/>	Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tanning booths?	<input type="checkbox"/>	<input type="checkbox"/>	Melanoma	<input type="checkbox"/>	<input type="checkbox"/>
Have you had blistering sunburns?	<input type="checkbox"/>	<input type="checkbox"/>	Basal Cell	<input type="checkbox"/>	<input type="checkbox"/>
Do you heal with thick (keloid) scars?	<input type="checkbox"/>	<input type="checkbox"/>	Squamous Cell	<input type="checkbox"/>	<input type="checkbox"/>
Do you bleed / bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal moles	<input type="checkbox"/>	<input type="checkbox"/>
Do you react to numbing medications?	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Do you react to bandages or adhesive?	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Do you need antibiotics for the dentist?	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Have you had staph infections / MRSA?	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke? # cigarettes/day _____	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune diseases	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol? drinks/day _____	<input type="checkbox"/>	<input type="checkbox"/>	(Lupus, Rheumatoid arthritis, MS, Crohn's, Colitis, thyroid)		
Do you work outdoors?	<input type="checkbox"/>	<input type="checkbox"/>			
Occupation: _____			<u>PMH: Circle your Medical Problems</u>		
Hobbies: _____			Cancer breast prostate _____		
			Immune HIV immune deficiency		
			Eye glaucoma cataract rosacea		
			Nose seasonal allergies chronic rhinitis		
			Heart high blood pressure heart attack		
			high cholesterol atrial fibrillation		
			heart valve problems clotting disorder		
			Lung COPD asthma tuberculosis		
			GI acid reflux colitis irritable bowel		
			Hepatitis B or C		
			Joint arthritis joint replacement		
			Brain stroke seizures migraine headaches		
			Endocrine thyroid diabetes polycystic ovary		
			Psych depression anxiety attention deficit		
			OTHER _____		
<u>ROS: Circle any Symptoms you are having below:</u>			Patient sign/date _____		
General weight loss fatigue			Doctor sign/date _____		
Immune fever night sweats frequent infections					
Eye dryness blurry vision irritation					
Heart chest pain ankle swelling palpitations					
Lungs shortness of breath cough					
GI nausea vomiting diarrhea					
Joint stiffness pain cramping					
Neuro numbness tingling headaches weakness					
Endocrine heat/cold intolerance excessive thirst					
Psych depression anxiety					
Heme easy bleeding bruising swollen nodes					
Skin itch burning redness discoloration scale					

Female's pregnant nursing irregular periods					
planning pregnancy soon birth control pills					