Name_____
Chart_____
DOB_____

Dermatology Specialists, P.A.
Medical History Form

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, Voluma, Juvederm, Veins, Hair removal, Wrinkles, Brown spots

ALLERGIES:_____

MEDICATIONS:_____

Skin Conditions and Social History	**Yes**	**No**
Have you had skin cancer?	□	□
Melanoma?	□	□
Basal Cell Carcinoma?	□	□
Squamous Cell Carcinoma?	□	□
Have you had abnormal / dysplastic moles?	□	□
Have you had pre-cancerous Actinic Keratoses?	□	□
Do you use sunscreen? SPF #_____	□	□
Do you use tanning booths?	□	□
Have you had blistering sunburns?	□	□
Do you heal with thick (keloid) scars?	□	□
Do you bleed / bruise easily?	□	□
Do you react to bandages or adhesive?	□	□
Do you need antibiotics for the dentist?	□	□
Have you had staph infections / MRSA?	□	□
Do you smoke? # cigarettes/day_____	□	□
Do you drink alcohol? # drinks/day_____	□	□
Do you work outdoors?	□	□

List any other skin conditions you have:
(Examples: Eczema, Psoriasis, Acne, Rosacea, Vitiligo)

_____

List any foreign countries you have visited in the past six months:_____

Occupation/Hobbies:_____

ROS: Circle any *Symptoms* you currently have:

General	weight loss	fatigue
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
Females	pregnant nursing	irregular periods
	planning pregnancy soon	birth control pills

Past Surgeries:	**Yes**	**No**
Pacemaker / Defibrillator	□	□
Joint replacement-Site:_____	□	□
Heart valve replacement	□	□
Organ transplant-Type:_____	□	□
Tubal ligation	□	□

List other surgeries_____

FAMILY Medical Problems:	**Yes**	**No**
Skin cancer	□	□
Melanoma?	□	□
Basal Cell Carcinoma?	□	□
Squamous Cell Carcinoma?	□	□
Abnormal moles	□	□
Eczema	□	□
Asthma	□	□
Seasonal Allergies	□	□
Psoriasis	□	□
Autoimmune diseases	□	□

(Lupus, Rheumatoid arthritis, MS, Crohn's, Colitis, thyroid)

PMH: Circle your Medical Problems

Cancer	breast prostate Colon	_____
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_____

Patient sign/date_____

Doctor sign/date_____