MEDICAL HISTORY (for Dermatology Appointment) (please print legibly)

Patient Name: ________________________________ Date of Birth: ____/____/____ Today's Date: __________

Phone: home: (____)______________ work: (____)____________ Age: ____

Reason for today's visit (circle one): RASH MOLES BUMPS SKIN CANCER PSORIASIS OTHER:

Are you allergic to any medications? ☐ Yes ☐ No

If yes, list: 1. ______________________________ 2. ______________________________

List all medications (pills) you are currently taking:	List all topical medications (creams, etc.) you are using:
1. ______________________________	1. ______________________________
2. ______________________________	2. ______________________________
3. ______________________________	3. ______________________________
4. ______________________________	4. ______________________________
5. ______________________________	5. ______________________________

SKIN HISTORY:

Have you ever visited a dermatologist? ☐Yes ☐No When? ______________

Reason? ____________________________ Treatment: ____

When you are exposed to the sun do you: ☐Tan only ☐Tan and burn ☐Burn

Would you describe your CURRENT (within last 2 years) sun exposure history as: ☐Minimal ☐Moderate ☐Maximal

Would you describe your childhood (pre-age 18) sun exposure as: ☐Minimal ☐Moderate ☐Maximal

Do you actively seek a tan ('laying out' or tanning bed)? ☐Yes ☐No Do you regularly use sunscreen? ☐Yes ☐No

Have you ever had skin cancer? ☐Yes ☐No If yes, what kind? ______________________________

Have you ever had blistering sunburns? ☐Yes ☐No

Do you form keloids (thick scars)? ☐Yes ☐No

Do you have a history of any specific skin diseases? ☐Yes ☐No

If yes, explain: ____

GENERAL MEDICAL: Do you have now, or have you ever had:

	Yes	No		Yes	No		Yes	No
Asthma	☐	☐	Seizures	☐	☐	Arthritis	☐	☐
Seasonal Allergy	☐	☐	Depression	☐	☐	Ulcers/Reflux	☐	☐
High Blood Pressure	☐	☐	Thyroid Disease	☐	☐	Lip/Fever blisters	☐	☐
Heart Valve Dis.	☐	☐	Diabetes	☐	☐	HIV Infection	☐	☐
Phlebitis	☐	☐	Glaucoma	☐	☐	Cancer	☐	☐
Blood clots	☐	☐	Cataracts	☐	☐	Hepatitis	☐	☐

SOCIAL HISTORY:

	Yes	No		Yes	No
Do you smoke cigarettes?	☐	☐	Do you drink alcohol?	☐	☐
Have you ever had local or dental anesthesia?	☐	☐	Do you need to take antibiotics before dental appointments?	☐	☐
Any bad reaction?..	☐	☐			
Are you pregnant or breastfeeding?	☐	☐			

What is your occupation?____

FAMILY HISTORY:

	Yes	No
Do you have any family history of skin cancer or skin disease?	☐	☐

List surgical procedures you have had in last 6 months: ______________________________________

List any other conditions you've seen a doctor for (not mentioned above):______________________________

Completed by: ______________________________ ______________

Patient/Parent (Signature) Date