DERMATOLOGY MEDICAL HISTORY FORM

Patient's Name: ______________________________ Age: __________ Height: __________

Prefer to be called: ______________________________ DOB: __________ Weight: __________

Did a doctor recommend you see a dermatologist? Y | N If yes, doctor's name: ______________________

For my prescription medications, I prefer: ❑ Brand Name only ❑ Generic only ❑ Either Brand Name or Generic

General Medical History: *Do you have or have you ever had any of the following?*

- ❑ Acne
- ❑ Anemia
- ❑ Angina/ Coronary artery disease
- ❑ Anxiety
- ❑ Arthritis? If yes:
  - ❑ Osteoarthritis ❑ Rheumatoid ❑ Psoriatic
- ❑ Asthma
- ❑ Basal cell or squamous cell skin cancer (where on body, when treated?)
  ____
- ❑ Bleeding disorder
- ❑ Blistering sunburns (how many & where?)
  ____
- ❑ Blood clots in legs (DVT)
- ❑ Blood transfusion (when?) ______________
- ❑ Cancer (what type, how treated, & when?)
  ____
- ❑ Congestive heart failure
- ❑ Crohn's disease or ulcerative col tis
- ❑ Depression
- ❑ Diabetes, controlled with
  - ❑ Diet ❑ Medication ❑ Insulin
- ❑ Eczema
- ❑ Emphysema or COPD
- ❑ Epilepsy or seizures
- ❑ Fibromyalgia
- ❑ Genital warts
- ❑ Have you been told to take antibiotics before dental procedures due to a heart murmur, heart valve, or artificial joint?
- ❑ Hayfever, seasonal allergies
- ❑ Heart attack
- ❑ Heart murmur or heart valve problem
- ❑ Hepatitis (what type?) A | B | C
- ❑ Herpes (what type?) Genital | Mouth
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ HIV or AIDS
- ❑ Kidney problems (what type?) ______________
- ❑ Liver cirrhosis or other liver problems
- ❑ Melanoma
- ❑ Organ transplant (what type?) ______________
- ❑ Osteoporosis
- ❑ Overgrown scars or keloids
- ❑ Pacemaker or defibrillator
- ❑ Psoriasis
- ❑ Reflux/ GERO/ Heartburn or peptic ulcers
- ❑ Rosacea
- ❑ Stroke
- ❑ Thyroid problem (what type?) ______________
- ❑ Tuberculosis

Surgeries:

- ❑ Abnormal moles proven on biopsy
- ❑ Appendix removed
- ❑ Artificial joint (If yes, which one & when?)
  ____
- ❑ Gallbladder removed
- ❑ Heart bypass surgery
- ❑ Heart valve replacement

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Female Patients:

- ❑ Are you pregnant or breastfeeding?
  If not, method of birth control? ________________
- ❑ Are you planning to get pregnant?
  If yes, when? __________________________________
- ❑ Hysterectomy? If yes:
  ❑ Uterus only ❑ Uterus & Ovaries
- ❑ Prone to yeast infections with antibiotics
- ❑ Tubal ligation (tubes tied)

Other Medical Problems or Surgeries: ____

____

Allergies to medications & type of allergic reaction *(example: hives, difficulty breathing, swelling)*: ________________

____

Medications *(Prescription, Non-Prescription, Vitamins, Herbs)*: ______________________________

____

Skin Type: *If first exposed to the sun in the summer without sunscreen, would you:*

❑ Always burn, never tan ❑ Always burn, sometimes tan ❑ Sometimes burn, always tan gradually

❑ Burn minimally, always tan well ❑ Rarely burn, tan profusely ❑ Never burn, deeply pigmented

Social History:

Do you smoke or use tobacco? Y | N If yes, number per day? ____

Do you drink alcohol? Y | N If yes, number per day? ____ per week? ____ per year? ____

Marital status: ❑ Single ❑ Married ❑ Divorced Children: Y | N If yes, number of children? ________

Hobbies: ____

Occupation/School: ____

Family History: *Circle any conditions affecting a blood relative. Specify who is affected below the circle.*

Melanoma | Basal Cell or Squamous Cell Skin Cancer | Breast Cancer | Psoriasis | Eczema | Hayfever or Allergies | Asthma | Acne

I would like more information about:

- ❑ Anti-aging topical products
- ❑ Botox (to treat wrinkles between the eyebrows, around the eyes, forehead, neck)
- ❑ Botox for excessive sweating of underarms, palms, soles
- ❑ Brown spots (liver spots) or discoloration on the face, hands, chest, arms
- ❑ Chemical peels
- ❑ Dark circles or deep tear troughs, sunken eyes
- ❑ Facial spider veins, "broken" blood vessels, or redness of the face
- ❑ Facials
- ❑ Fillers such as Restylane, Radiesse, Juvederm, Perlane, Sculptra, Collagen to treat winkles or volumize areas
- ❑ Laser hair removal
- ❑ Microdermabrasion
- ❑ Mineral make-up
- ❑ Skin care or product advice
- ❑ Spider veins on the legs
- ❑ Sunscreens

Signature of Patient: ____ Date: _____/_____/_______

Updated: ____