Dermatology Medical History

Patient Name: ______________________ Date: ______________

Date Of Birth: __________ Age: ______ Gender: M F Social Security #: ______________

General Information

Address: ______________________ Phone (Home): ______________

______________________ Phone (Work or Daytime): ______________

______________________ Phone (Cell): ______________

Email: ______________________

Medical Record Information

Referring Physician; __________ Contact Information:: __________ Send Records? Y/N

Primary Physician: __________ Contact Information:: __________ Send Records? Y/N

Other Physician: __________ Contact Information:: __________ Send Records? Y/N

Other Physician: __________ Contact Information:: __________ Send Records? Y/N

Medical Information

Allergies ____

____

Medications - List all medications you are currently taking (include prescriptions, over-the counter meds, vitamins and herbal supplements):

1.	2	3.	4.	5.
6.	7.	8.	9.	10.
11.	12.	13.	14.	15.

Surgical History - List all previous surgical procedures:

1.	2.	3.	4.
5.	6.	7.	8.

Medical History (Circle all that apply)

Bronchitis	Pacemaker	Kidney Transplant	Intestinal Problems
COPD/Emphysema	Heart Transplant	Dialysis	Bladder Problems
Asthma	Heart Valve Replacement	Seizures	Prostate Disease/Cancer
Tuberculosis	Diabetes	Stroke	Joint Replacement
Lung Cancer	Liver Disease	Bleeding Disorder	Arthritis
Sarcoidosis	Liver Transplant	Thyroid Disease	Reproductive Tract
High Blood Pressure	Hepatitis	Depression	Problem
Heart Disease	Kidney disease	Stomach Ulcers	

Your Personal Skin History: (Circle all that apply)

Basal Cell Carcinoma   Squamous Cell Carcinoma   Melanoma   Dysplastic/Atypical Moles

Precancers   Psoriasis   Eczema   Lupus   Keloids

Please list any other diseases or conditions: ______________________________________

____

Social History: Do you smoke? No Yes If yes, how many packs per day? __________________

Do you drink alcohol? No Yes If yes, how many drinks per day? __________________

Family History: (Circle all that apply)

Melanoma ______________ Skin Cancer ______________ Psoriasis ______________ Eczema ______________

______________________________ ______________________

Patient Signature   Date

______________________________ ______________________

Reviewed by   Date