

Dermatology Medical History

Patient _____ Date ____/____/____

Are you allergic to any medications? ____ YES ____ NO If yes, list below:

1. _____ 2. _____

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Do you have: **High Blood Pressure** ____ YES ____ NO **Diabetes** ____ YES ____ NO

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin: Have you ever had skin cancer? ____ YES ____ NO

Has anyone in your family had skin cancer? ____ YES ____ NO

Do you have a history of any specific skin diseases? ____ YES ____ NO If yes, _____

Do you have problems with healing? ____ YES ____ NO

Do you bleed easily? ____ YES ____ NO

Do you develop skin rashes in reaction to ____ Medications ____ Food ____ Environment

____ Bandages ____ Topical Neosporin

____ Other _____

Do you require antibiotics for dental work? ____ YES ____ NO

Do you have any artificial body parts, such as a joint replacement or artificial heart valve? ____ YES ____ NO

Do you smoke: ____ NO ____ YES How much? _____

Do you drink alcoholic beverages? ____ NO ____ YES How much? _____

Are on on: ____ Blood Thinners ____ Aspirin

____ Anti-inflammatory medicines such as Ibuprofen, Naprosyn, Motrin, Alleve, etc.

(Women) Are you pregnant? ____ YES ____ NO Due Date: ____/____/____

Are you breastfeeding? ____ YES ____ NO