

## DERMATOLOGY MEDICAL HISTORY/REVIEW OF SYSTEMS

Pt Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Are you allergic to any medications?  YES  NO If yes, list: \_\_\_\_\_

Have you ever had dental anesthesia (Novocaine)?  YES  NO Any bad reactions?  YES  NO  
 List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins & herbals): \_\_\_\_\_

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

<b>Lungs:</b>	YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurological</b>	YES	NO
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cardiovascular:</b>	YES	NO
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis (Inflammation of vein)	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
<b>Reproductive</b>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular menstrual	<input type="checkbox"/>	<input type="checkbox"/>

<b>Other Systemic:</b>	YES	NO
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>
<b>Psychiatric</b>	YES	NO
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>
Aggressive Behavior	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal ideation	<input type="checkbox"/>	<input type="checkbox"/>
<b>Musculoskeletal/Joints:</b>	YES	NO
Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
<b>Gastrointestinal:</b>	YES	NO
Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Nausea, vomiting, diarrhea when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Yeast infection when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases or conditions: \_\_\_\_\_

List surgical procedures you have had in the last six months: \_\_\_\_\_

Have you had chest/breast augmentation?  YES  NO

<b>Skin:</b>	YES	NO	If Yes, explain below:
Have you ever had skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>	
Has anyone in your family had skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a history of any specific skin diseases?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have problems with healing?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you develop keloids (scars) after surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you develop skin rashes in reaction to: <input type="checkbox"/> Medications <input type="checkbox"/> Food <input type="checkbox"/> Environment <input type="checkbox"/> Bandages <input type="checkbox"/> Topical Neosporin <input type="checkbox"/> Other: _____			

### Social History:

Do you drink alcohol?  YES  NO If YES: \_\_\_\_\_ drinks per day

Do you use recreational drugs?  YES  NO If YES, what? \_\_\_\_\_ How often? \_\_\_\_\_

Do you smoke?  YES  NO If YES, how much? \_\_\_\_\_  
Have you had or have you been exposed to HIV (AIDS)?  YES  NO

Please answer the following questions:

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

What is your occupation? \_\_\_\_\_ Hobbies? \_\_\_\_\_

Completed by  Patient

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_