PT #__________

DERMATOLOGY MEDICAL HISTORY

Name:______________________________Date of Birth:______/______/______Today's Date:_____/_____/______

Best phone number(s) to contact you:________________________________ Preferred pharmacy:__________________

Reason for today's visit:____ Started when?_________________________

Are you allergic/intolerant to any medications, anesthetics, bandage adhesives, or foods? No Yes If yes, please list:

1.______________________2.______________________3.______________________4:_________________________

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

1.______________________2.______________________3.______________________4:_________________________

5.______________________6.______________________7.______________________8:_________________________

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

Cardiovascular:	**YES**	**NO**
High blood pressure	☐	☐
Elevated cholesterol	☐	☐
Heart attack or angina	☐	☐
Leg cramps after walking	☐	☐
Pacemaker/Defibrillator	☐	☐
Do you take blood thinners?	☐	☐
Lungs:		
Asthma	☐	☐
Emphysema	☐	☐
Chronic cough/sinusitis	☐	☐
Lung cancer	☐	☐
Other lung problem____________________		
History of **tuberculosis**	☐	☐
Internal cancer(s)	☐	☐
Type:_________________________________		

Other Systemic Problems:	**YES**	**NO**
Diabetes	☐	☐
On insulin?	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
On dialysis?	☐	☐
Bladder	☐	☐
Diagnosis:________________________		
Stomach, intestines, liver	☐	☐
Diagnosis:________________________		
Neurologic disorder	☐	☐
Diagnosis:________________________		
Arthritis	☐	☐
Type:______________		
Artificial joint	☐	☐
Which one(s)?_____________________		

List **any other diseases** or conditions:____

List **past surgical** procedures:____

Women: Are you **pregnant?** ☐ Yes ☐ No If yes, due date:______________________ Breast feeding? ☐ Yes ☐ No

Skin: (New Patients) Have you ever had **skin cancer**? ☐ No ☐ Yes, type and location(s)____________________________

Has anyone in your **family** had melanoma? ☐ No ☐ Yes If yes, which person?____________________________

Do you have a history of specific **skin diseases** (**eg.** Psoriasis)? ☐ No ☐ Yes______________________________

Do you develop **keloids** (unusually thickened scars) after skin injury? ☐ Yes ☐ No

Social History: Do you drink **alcohol**? ☐ Yes ☐ No If yes, ______________ drinks per week

Do you **smoke**? ☐ Yes ☐ No If yes, how many packs per day?______________ Since what age?_____________

What is your **occupation** (former, if retired)?___________________________Hobbies?____________________________

Patient Signature:____Reviewed by:__________________________

PQRI UPDATED______________________ Notes/updates:____