

PATIENT MEDICAL HISTORY

Date: _____

Patient's Name: _____
Please print

Employer: _____ **Occupation:** _____

Please select one: **Smoker** **Non-Smoker**

Who referred you?

Physician Insurance Family Member
 Phone Book Advertisement Friend _____

Please answer questions 1-8 in regards to your single most important dermatologic problem:

1. What is your current skin condition that you are seeing the physician for today? .

2. How long have you had your skin condition and has it changed over time? _____

3. Where on you body is the problem located? _____

4. Does your skin condition itch, burn, sting, hurt, other (specify including severity)?

5. Please list all current and previous treatment for the skin condition:

6. Does anything seem to make your skin condition better or worse? (specify)

Please list all of your current medications (including over the counter medications) that you are taking for all your medical problems.

Please list all allergies or bad reactions to medications or any substances (describe reaction):

Check yes or no for YOUR past and present personal health history. (Do not include family history).

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Personal history of skin cancers, precancerous (actinic keratosis) or melanomas. Specify type: _____ Specific treatments: _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease including valve problems, pacemaker, angina or other _____
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding or clotting
<input type="checkbox"/>	<input type="checkbox"/>	Tendency to form large scars or keloids
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or high blood sugar
<input type="checkbox"/>	<input type="checkbox"/>	History of cold sores, fever blisters.
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure (Hypertension)
<input type="checkbox"/>	<input type="checkbox"/>	History of hepatitis, liver disease or jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcer or other gastrointestinal problems (specify) _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma or other respiratory problems (specify) _____
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (specify) _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney or urinary problems (specify) _____
<input type="checkbox"/>	<input type="checkbox"/>	History of internal cancer (specify) _____
<input type="checkbox"/>	<input type="checkbox"/>	Neurological or psychiatric problems (specify) _____
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma or other eye problems (specify) _____
<input type="checkbox"/>	<input type="checkbox"/>	Hay fever
<input type="checkbox"/>	<input type="checkbox"/>	Recent fevers, sweats, or chills (specify) _____
<input type="checkbox"/>	<input type="checkbox"/>	Any hormonal problems (specify) _____
<input type="checkbox"/>	<input type="checkbox"/>	Known to be HIV positive
<input type="checkbox"/>	<input type="checkbox"/>	At risk for HIV infection * (Aids Virus Infection) e.g. previous blood transfusions, homosexual activity, IV drug abuse, multiple partners, sexual contacts at risk (specify) _____
<input type="checkbox"/>	<input type="checkbox"/>	Other information pertinent to your health NOT listed above (specify) _____

Completed By: Patient
 Nurse/MA

Physician Signature

Date